



**Migrant Arab Muslim Women's experiences of  
Childbirth in the UK**

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## ABSTRACT

This research study explored the meanings attributed by migrant Arab Muslim women to their experiences of childbirth in the UK. The objectives of the study were:

- To explore migrant Arab Muslim women's experiences of maternity services in the UK.
- To examine the traditional childbearing beliefs and practices of Arab Muslim society.
- To suggest ways to provide culturally sensitive care for this group of women.

An interpretive ontological-phenomenological perspective informed by the philosophical tenets of Heidegger (1927/1962) was used to examine the childbirth experiences of eight Arab Muslim women who had migrated to one multicultural city in the Midlands.

Three in-depth semi structured audiotaped interviews were conducted with each woman; the first during the third trimester of pregnancy (28 weeks onwards), the second early in the postnatal period (1-2 weeks after birth) and the third one to three months later. Each interview was conducted in Arabic, then transcribed and translated into English. An adapted version of Smith's model of interpretive phenomenological analysis (Smith 2003) together with the principles of Gadamer (1989) were used to analyse the interview data, aided by the use of the software package NVivo2.

The analysis of the women's experiences captures the significance of giving birth in a new cultural context, their perception of the positive and negative aspects of their maternity care and the importance of a culturally competent approach to midwifery practice. Six main themes emerged from analysis of the interviews: 'displacement and reformation of the self', 'by the grace of God', 'the vulnerable women,' 'adaptation to the new culture,' 'dissonance between two maternity health systems' and 'the valuable experience'. These themes reflected the women's lived experiences of their childbirth in the UK.

The implications for communities, institutions, midwifery practice and further research are outlined. The study concludes that in providing culturally competent care, maternity caregivers should be aware of what might be significant in the religious and cultural understandings of Arab women but also avoid cultural stereotyping by maintaining an emphasis on individualised care.

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# **AUTHOR DECLARATION**

I declare that the main text of this thesis is entirely my own work. This work has not previously been submitted wholly or in part for any academic award or qualification other than that for which it is now submitted.

Hala Bawadi

2009

Signature

.....

Date

.....

# DEDICATION

## To my children

This study is dedicated to my children Masa, Mohammed and Awab for their love, care, support and understanding. I will never forget how much you have suffered along with me. We cried almost every day because of the isolation we lived in.

**Masa** – I always remember your words, “I am so proud of you mum, you are my role model, I want to become like you”. You were the only one who was close to me the whole time, and who was so enthusiastic in giving me strength.

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I promise you, my children that our suffering is at an end. We will be a family together; we will never be far from each other. Please forgive me for putting you under this stress.

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# **PUBLICATION ARISING FROM THE THESIS**

## **Conference Papers**

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Bawadi, H. Cully, L. And Harris, T (2009). Poster Presentation. “Giving Birth in A New World”. 10<sup>th</sup> Annual Interdisciplinary Research Conference: Transforming Healthcare through Research & Education 4<sup>th</sup> & 5<sup>th</sup> November 2009 Dublin

# **CHAPTER ONE**

## **INTRODUCTION CHAPTER**

### **1.1 Introduction**

According to official UK government estimates, in 2005 approximately 1,500 immigrants arrived in the UK every day (Allhutt 2006). Worldwide an estimated 190 million people are now living outside their countries of birth or citizenship, and the rate of this migration is expected to remain high (Jentsch 2007). The resulting growing cultural and ethnic diversity in societies creates specific challenges for those delivering public services such as health care. Immigration may bring with it many problems, including racism, negative stereotypes and inequality in health care provision (Sword et al 2006). Of particular relevance for Arab Muslim migrants is the increased discrimination which has occurred since the September 11th attack in New York in 2001 and the July 2005 bombings in London (Cainkar 2004, Ken 2006).

Globally, about half of the migrant population are women (Jentsch 2007). In the UK itself, 53 per cent of foreign nationals are women (Research Development and Statistics Directorate 2001) and maternal and reproductive health is thus of major importance. As shown later in this discussion, pregnancy outcomes of migrants are known to be poor, showing significant disparities when compared with those of indigenous populations (Macfarlane 2000). This highlights the need for investigation in this area.

This study focuses on the experiences of migrant Arab Muslim women in the UK.

I have elected to commence this chapter by outlining how I became interested in the experiences of migrant Arab Muslim women and by revealing something of my own philosophy. Consideration is then given to the rationale and aims of the study. This is followed by discussion of relevant key concepts. The chapter concludes with an outline of the organisation of the complete thesis.

## 1.2 My Philosophical Background

What does it mean to be a migrant Arab Muslim woman experiencing childbirth in the UK? This is the question this thesis addresses. The question arose from my own experience as a midwife from Jordan working with multi ethnic women in one of the Gulf countries. I am a migrant Arab Muslim woman and though I have not experienced childbirth in the UK, I did have three children in an Arab country different to my own. I understand what it is like to be a woman giving birth away from family, in another country with a different culture and language. The intention behind this study is to share this understanding with midwives involved in the care of migrant women. Greater understanding of this phenomenon will enable midwives to deliver the best possible care for this client group. I know midwives can manage the clinical aspects of care, but this is not enough: in order to provide holistic care, midwives must understand the meaning women attribute to their own experiences and endeavour to meet their cultural and spiritual needs.

I commenced this study with strong misgivings, due to my migration to the UK with three young children. My husband was already here, completing the final year of his PhD, but he then had to leave me and our children and return to Jordan. Thus, I was obligated to manage without any family support. I was afraid that I could not successfully complete my PhD. I was not sure of my ability to balance family life with the rigours of research. These anxieties affected me deeply and changed the way I engaged with the world.

In my new life, I became aware of many things about myself, and realised that I could live with my family in this new world without the help of a man and my extended family. Such assistance is a normal part of social life for women in Arab society. My experience enabled me to break with Arabic tradition and the hierarchical structure of the Arab family. I embraced this independence. However I also became aware of misconceptions in the UK regarding Arab women in relation to their roles within Arab society; that they are always controlled by males and ‘suffering in silence’. Contrary to such stereotypes, I am an example of an independent Arab woman who can successfully both raise her children and study without support or control by male members of my family. I consequently ‘found my feet’ and was able to believe in my abilities and those of other Arab women to achieve success if given the opportunity.



I became aware of the western stereotyping of the role of women and men in Arab culture and began to understand that Arab men and women's roles were a product of a sometimes harmful tradition, and that individuals behave in a specific way because they are imbued with this culture, but that this can be transformed. This is evident in the way my husband acted towards me, adapting from a traditional to a more democratic role within the family as a result of migration. I believe the Arab younger generation wants to change this view of themselves, and they are already changed in many aspects. The problem is the dominance of such cultural norms over hundreds of years.

From my own personal experience, I disagree with the Western view of the Arab Muslim world, and I regard one of my responsibilities as explaining the reality of my world at the present time. During my research journey, I changed my blind acceptance of the view that Arabic women are always marginalised in Arab culture. I have since learned to regard my Arab sisters holistically, as human beings, existing in this world. As a consequence of this and of my reading of existentialist philosophies, I developed an interest in the philosophical writings of Martin Heidegger, upon which I have based the methodology of this study.

My interest in his philosophy led me to explore new hermeneutic meanings. It was a journey to understand myself and to search for new meanings of my life as a woman. My own philosophical outlook underwent considerable changes as I came to understand the concept of being, changes that have continued as this study has progressed.

As I began my journey of self-discovery I examined my existing knowledge so as to achieve a considered self-understanding. This then fed back into this study. Eventually I became aware of the changes in my interpretation of the words of the women who participated in it. I was incorporating the women's words into my own hermeneutic circle and comprehending them through my new self-understanding. I consciously experienced the fusing of horizons between my own circle and those of the women, as discussed in detail in the methodology chapter in the present work, under the heading "hermeneutic circle". As my pre-knowledge influenced my analysis of the data, so the women's stories were simultaneously governing my own understandings of myself as a human being.

### **1.3 Philosophical Framework**

The philosophy underlying this research study was Heideggerian Hermeneutic phenomenology, which in the present case involved understanding the meaning of what it means to “be in the world” as a migrant Arab Muslim woman experiencing childbirth in the UK. The exploratory and interpretive nature of this study, with its emphasis on understanding the childbirth experiences of migrant Arab Muslim women in the UK, led to the choice of Heideggerian hermeneutic phenomenology as a methodology. This methodology affirms the significance of the reality experienced by individuals and the meanings ascribed to these experiences. It relies on an interpretive perspective: it endeavours to understand the meanings people attribute to their world (Rees 2003).

### **1.4 Aims and Objectives**

The main aims of this study were to explore the experiences of migrant Arab Muslim women who have utilised maternity services in the UK, and to provide an original contribution to knowledge with regard to the health care needs of migrant Arab Muslim women accessing maternity services.

The specific objectives for this study are:

- To explore migrant Arab Muslim women's experiences of maternity services in the UK.
- To examine the traditional childbearing beliefs and practices in Arabic Muslim society.
- To suggest ways to provide culturally sensitive care for this group of women.

The outcomes of this study may provide health care professionals in the UK with a unique insight into the social and cultural context of women whose experiences may be very different from their own. The findings may assist midwives and other health care providers to recognise issues which may be important to these women, and respond to those issues in ways which enhance their experiences and improve outcomes for them, their children and their families.

## **1.5 Rationale for the Study**

Health disparities in the UK exist among and within ethnic communities. Social class affects the degree of these variations in levels of health among these groups (Randhawa 2007). This argument is supported by a report released by the Department of Health on Tackling Health Inequalities. "There are wide geographical variations in health status, reflecting the multiple problems of material disadvantage facing some communities. These differences begin at conception and continue throughout life. Babies born to poorer families are more likely to be born prematurely, are at greater risk of infant mortality and have a greater likelihood of poverty, impaired development and chronic disease in later life. This sets up an inter-generational cycle of health inequalities" (DOH, 2002, p.1).

People from ethnic minorities are more likely to experience poor living and working conditions than the population as a whole. In addition, they may experience negative treatment from the indigenous population. This can happen in their contact with public services as well as in the private sphere. The Home Office Citizenship Survey (HOCS) conducted in 2005 found that one in five respondents from ethnic minority communities expressed their fear of being physically attacked because of their physiognomy, ethnicity or religion (Kitchen et al, 2006). The 2001 UK population census found that, after Christianity, Islam was the most common faith, with nearly 3 per cent (1.6 million) describing their religion as Muslim (Office of National Statistics 2001). Just 46 per cent of the Muslim population living in the UK at the time of the 2001 census were born in the UK, the other 54 percent migrated to the UK (Ken 2006). It has been suggested that Muslim patients in particular may experience several forms of racism in their accessing of health services (Karlsen 2007). Exploring and challenging racism in health services is essential to the development of effective strategies to decrease health inequalities among ethnic populations.

Communication failures are the biggest cause of complaints in health care generally in the UK (Cortis 1998). This is more so for people from ethnic minorities, particularly those who speak little or no English. Both the lack of appropriately trained interpreters and a difficulty in accessing services puts health professionals in a very difficult position in delivering effective care and makes it impossible for some health care workers to obtain relevant information on which to base this care (Pollock 2005).

There is a considerable body of evidence on health inequalities in ethnic minority communities in the UK, including studies concerned with minority women's access to and views of maternity care ( McCourt and Pearce 2000, Davies and Bath 2002, Richens 2003, Ali and Burchet 2004). Some of these studies have examined the health needs of Muslims patients in particular. Traditional Muslim beliefs and practices can influence the health needs of this group of people. According to a Maternity Alliance report, many Muslim women receive inappropriate maternity care that puts their babies at risk (Pollock 2005). This research was based on interviews with women from around the UK and suggests that some maternity services in the NHS are insensitive to the needs of Muslim women and their partners.

One of the key issues identified by researchers concerns staff and hospitals failing to respect Muslim women's privacy, resulting in acute discomfort and embarrassment during pregnancy and childbirth. According to Pollock (2005) many problems are caused by a lack of understanding about the Muslim faith, but some were associated with discrimination . Head of Policy, Information and Campaigns at the Maternity Alliance, Ruba Sivagnanam said: "Our research into Muslim parents' experiences of the maternity services in England found that whilst some women receive good quality maternity care, many do not. Maternity services must be informed and shaped by the diverse needs of the communities they serve. Increasing accessibility and quality of maternity care will improve health outcomes in the UK's black and minority ethnic communities, including Arab Muslim communities" (Pollock 2005 p55).

There is considerable controversy about the factors contributing to poor birth outcomes in minority ethnic women. Cultural practices and beliefs about pregnancy and childbirth have often been blamed for the poor uptake of maternity services, but it is also important to recognise that many women from minority ethnic communities are prevented from making effective use of maternity services due to language and communication problems, intrusive examinations, lack of explanation, negative stereotyping and the racist attitudes of health professionals (Katbamna 2000). Studies have shown that many midwives lack confidence that women's consent to screening, scanning or procedures during delivery could be truly informed without the same level of debate and discussion that they perceive is given to women who speak English well (Sim 2005). Some hospital midwives have also indicated that their ability to provide emotional reassurance and support during labour is compromised in women with limited English speaking skills (Sim 2005).

In the UK there is evidence of late booking or infrequent attendance at antenatal care facilities for women from specific socio-demographic groups (CEMACH, 2007). The same source shows that black African women are six times more likely to die during pregnancy or within a short period after delivering than are British women. Knight et al (2009) aimed to investigate severe maternal morbidity in non-white women using the UK Obstetric Surveillance System (UKOSS). The findings indicated that the risk of severe maternal morbidity is significantly higher in ethnic minority women compared to white women, even allowing for differences in age, socioeconomic status, smoking, body mass index and parity. The estimated rate of severe maternal morbidity was 126 cases per 100,000 for minority women and only 80 cases per 100,000 for white women. One of the factors to which these differences have been attributed is care during childbirth. Knight et al (2009) highlight the importance of tailoring maternity services to the needs of non-white women, in order to improve their access to maternity services. These issues are discussed in more detail in the next chapter.

In light of the critical issues raised above, this study proposes to investigate what pregnant migrant Arab Muslim women want and need from maternity services, by exploring the lived experience of migrant Arab Muslim women who have used maternity services in the UK.

## **1.6 Key Concepts**

Participants in this study are drawn from a population of migrant Arab Muslim women from several countries. The following concepts are relevant to the study and are briefly discussed in this section: migration; culture and cultural competence; ethnicity; race; racism; religion; Islam; Arabic world; Arabic culture; and women in Islam.

### ***1.6.1 Migration***

In the UK, the term migrants or immigrants is used loosely to refer to individuals who have come from another country to live in the UK. This includes those individuals who have been in the country for both short and long periods of time, as well as permanent and temporary residents. Migrants are a very diverse group of people who come to the UK for a variety of

reasons including socioeconomic factors, for education, to seek asylum from political persecution and as refugees (Glover et al 2001).

**Migration:** is a word which originates from the Latin word "migratio" (the verb to move). Zohry (2005) defined migration as a movement that changes the residence of individuals over a considerable distance. International migration is the shifting of residents outside the perimeter of their home country (Zohry 2005). The expression 'migrant' is connected with movement; one can leave one's country of origin and move to other countries in the world, and one might also go back to one's country of origin. Measurements of migration could therefore include individuals moving out of or returning to a country. In the context of this study the term migration will be used and is defined as individuals who have moved to the UK to live as temporary or permanent residents.

**Immigration:** is a word that refers to movement to a country for the purpose of permanent residence. Immigration has important attendant political and socioeconomic circumstances. Around half a million Arabs live in the UK (BBC 2005). The majority live in London and originate from Egypt, Morocco, Palestine, Yemen, Lebanon, Iraq and the Gulf States. There have been four major waves of Arab immigration to the UK. The first wave in the 1940's was from Egypt, the second (in the 1960's) coming mainly from Egypt and Morocco in search of employment. The third occurred in the 1970's. With the sourcing of oil in the Gulf, Arabs from this region arrived in the UK to develop business opportunities. In addition, civil war in Lebanon also impacted on immigration rates. In the 1980's there was migration from Iraq by political refugees and asylum seekers. Many Arabs who settled in the UK opened lucrative coffee shops and pastry shops all over London. The hotel and catering industry attracted professional and unskilled workers, especially from Morocco and Palestine. The Arab community concentrated in the centre of London along the Edgware Road and in the Borough of Westminster, one of the most expensive areas to live. By contrast, some Arabs such as those from Morocco settled in more deprived areas (BBC 2005).

Migration presents many problems including racism, inequality in health care services and loss of such protective support factors as family support and cultural orientation, which may be associated with increased physical and psychological illness. Therefore consideration needs to be given to exploring the concept of culture and its effect on health and wellbeing in migrant populations.

### ***1.6.2 Culture***

The term culture has been so widely used that its precise meaning varies from one set of circumstances to another. Culture in its broadest sense refers to peoples' ideas, values and concerns or expected patterns of behaviour. Culture is not inherited by genes but is a set of values and beliefs shared by groups within society (Hall 1976, p.16) which influences every aspect of life (Hutnyk 2006).

The first comprehensive definition of culture was formulated in 1871 by the British anthropologist, Sir Edward Burnett Taylor as “the complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society” (Haviland, 1994 p 304) . So culture is a medium of communication, not only with reference to verbal and nonverbal language, but also to the way in which a person experiences the world in general, and the way in which other people experience and respond to that person.

Understanding the concept of culture is a key to understanding human behaviour. Anthropologists describe culture as a system of shared meanings. People who identify themselves with a racial or ethnic group are assumed to share the same culture. This assumption is over-generalised, however, because not all members of society will share the same culture, and they may identify themselves with different social groups to which they feel a stronger cultural tie , for instance being Catholic, teenage, gay or lesbian (Henley and Schott 1999).

Kluckhohn and Strodtbeck (1961) define culture as the configuration of learned behaviour and results of behaviour whose component elements are widely shared and transmitted by the members of a particular society. For Hofstede (1980, p. 21) it is “the collective programming of the mind which distinguishes the members of one group from another”. Programming is passed from generation to generation, and will change over time because each generation will add something before passing it on. Goodenough (1981) argued that culture is a set of beliefs or standards/norms which legitimise those social practices shared by a group of people which

help the individual decide what is, what can be, how to feel, what to do and how to go about doing it.

While culture has been conceptualised in many ways, social scientists generally agree that it is a set of learned behaviours shared by a particular group of society or shared meanings assigned by culture members to things and persons around them. Hofstede's says "the mind stands for the thinking, feeling and acting with consequences for belief, values, attitudes and skills" (Hofstede's 2001 p10). Cultural influences tend to dictate the behaviour that is acceptable within a given society, regulating activities and enabling those affected by it to achieve a sense of individual and communal identity. Culture influences not only how the individual person internalises cultural belief systems, but also how they interpret the phenomenological world through their learned lens of meaning (Hofstede 2001).

Discourse of cultural ownership is linked with issues of identity which in turn is built up by a variety of factors such as ethnicity, racial origin, nationality, language and gender. However, while culture itself is embedded into all of these, it is not necessarily interchangeable with any one of them. Culture resides rather in the practice of a group of individuals (Isar 2006).

Culture can be viewed as a way of life, a way of viewing the world and a way of dealing with each other. Culture includes customs, behaviour, tradition, ethnicity, language, religious belief, beliefs regarding health and illness, gender, social economic class, age, sexual orientation, geographical origin, education, music, clothing, interaction/communication patterns and life experiences (College of Registered Nurses of Nova Scotia 2006).

According to Spradley and McCurdy (1994) culture is learned and shared. Human beings have learned to be extremely adaptable. We regularly adjust to new situations, environments and contexts, enduring all manner of change. Although it was once a survival principle, however, adaptability now tends to assume a less urgent quality. Moreover, there are times when individuals actively modify and reconstruct the situations and environments they work and live in. Within emerging sub-cultures the same rules apply (Wheeler and Nistor 2003).

Among this variety, there is no agreement on a single definition of the term. Culture represents our differences, as it enables individual's adaptation to the complex environment around them. To avoid confusion, culture has been defined in this study as common values,



beliefs, traits, traditions and languages that are learned and shared by members of a group. It is the predominant force that shapes behaviour, values and institutions. Culture colours the internal lenses through which people view the world (Helman 2001) and how they relate to it. Therefore, culture and language have a significant effect on how individuals access and respond to health care services (Ariff and Beng 2006).

However, it is important not to adopt an essentialist view of culture (Phillips 2007). Culture is a framework containing a range of choices and options for each of us; within this framework we can express our individuality and live our life in a unique way. Henley and Schott (1999 p3) argue “we all have a culture, but our culture does not define us”. Individuals should not be viewed as ‘cultural dupes’ (Phillips 2007). Within cultural systems people can exercise agency and may challenge or resist aspects of the dominant culture.

It is also important to recognise that culture is one important influence on behaviour but should not be seen as dictating action in all circumstances (Ahmad 1996). Culture is mediated by other social structural forces such as class, gender relations and age.

Because culture is not fixed or static people within the same ‘culture’ may have different set of norms, values and attitudes, different micro-cultures.

There are obviously important similarities between Arab Muslims, but it is also crucial to recognize individual variations among Arab Muslim women according to national identities, social class, educational background and age. In this context ‘Arabic culture’ does not represent a cultural essentialism that is “...the process by which particular groups come to be described in terms of fundamental, immutable characteristics, inherent within an individual or social group which determine their nature and the manner in which that nature is expressed” (May 1999 p34). Culley and Dyson (2005) argue that essentialism ignores the variations within groups. Cultural essentialism is a really problematic issue for ethnic minority people accessing NHS services. Health care practitioners may view people from different cultural groups as being the same, but individual variations must be addressed when delivering health care to Arab Muslim women. The thesis argues that within NHS maternity services, midwives need to acknowledge the importance of culture but should avoid essentialising Arab Muslim women as belonging to a rigid culture which defines their responses and experiences in specific way. Midwives in delivering care to Arabic Muslim women should

acknowledge the heterogeneity of Arabic culture and the individual agency of Arabic Muslim women.

In this research understanding the potential impact of culture on the experience of Arab Muslim women is nevertheless seen as crucial to the provision of effective care. Culture may lead women to view experiences quite differently from their carers; to hold different views of how things should be done, and to behave and express their feelings in ways diverging from cultural norms of the society they are currently living in. Arab Muslim women need health care which values their cultural norms, provides them with culturally competent care and demonstrates sensitivity to their beliefs and values. The term “culturally competent care” will be explored because culture plays a significant role when providing care to groups from different cultural and ethnic backgrounds.

### ***1.6.3 Culturally Competent Care***

Many definitions of “cultural competence” exist in the literature, but there is no consensus on what the term means. Leininger (1999), the founder of Culture Care Diversity and Universality Theory, simply defined cultural competent care as "to provide care that is meaningful and fits with cultural beliefs and lifeways" (Leininger 1999 p9). Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs (Betancourt et al 2002). As British society becomes more heterogeneous healthcare professionals need to bear many things in mind when providing culturally competent care. These include valuing diversity, maintaining an orientation towards the values and beliefs of the society being served, and the adaptation of care based on the cultural norms and traditions of individual clients and families (Kettering General Hospital NHS Trust 2008).

Cultural competence is developmental, a continuous dynamic process of learning and sharing. It will not come only by reading books or attending workshops. In order to provide culturally competent care it is important to know about the cultures of the client group and to ask respectful non-judgemental questions rather than making assumptions.

Meleis (1999) argued that a culturally competent person is a person who is able to recognise differences and balance his or her own caring actions, avoid stereotyping, and identify the pattern of responses.

Cultural competence is a process born of a commitment to provide quality care by being respectful of and responsive to the cultural factors that may influence patients' attitudes and behaviours at the institutional level. This will be achieved by supporting policies for employing people from different cultures. At the individual level cultural competence is achieved by respecting the cultural background, values, beliefs and practices of clients, families, communities and the population. It has been found that patients tend to seek care, follow the health care plans and are more satisfied when receiving care from healthcare professionals who demonstrate culturally competent care (College of Registered Nurses of Nova Scotia 2006). This concept will be explored later in the study.

Providing culturally competent care will make a difference to the health outcomes and will build rapport with patients belonging to minority groups. So the role of the healthcare provider is to bridge the gap between the system and the patient.

It is suggested that the initial step to being culturally competent is self-awareness and cultural sensitivity. On one hand self-awareness means being knowledgeable regarding one's own culture and being honest in facing and dealing with personal prejudices (Orlando Regional Healthcare, Education and Development 2004). On the other hand Garity (2000) asserts that being sensitive toward different cultural groups includes being aware of the effect of factors such as immigration, stress, a perceived lack of harmony in a person's life, family influences, poverty, language barriers, retaining face, myths, taboos, praying and spirituality and the potential for these factors to enhance or inhibit professional practice.

Abrums and Leppa (2001) argue that to provide culturally competent care issues of gender, class or sexual orientation also need to be considered. These issues involve care that is based on understanding of how those differences may inform the responses of people and the processes of caring for them. In the United States communication skills are added to knowledge and awareness as one of the three components of cultural competence (Orlando Regional Healthcare, Education and Development 2004). Moreover Abrums and Leppa

(2001) also explain that language barriers and miscommunication play an important role in inequality when accessing health services. It has been found that a major complaint about healthcare services comes as a result of such communication problems. The healthcare provider must have the ability to act skilfully when communicating with individuals and groups from different cultures and function effectively in both aspects of communication, speech (verbal communication) and body language (nonverbal communication) (Orlando Regional Healthcare 2004). In addition Meleis (1999) insists that one property of individuals who are culturally competent is their knowledge of how language might affect people's perception, understanding, meaning and making sense of the things around them, as well as how language and communication may influence the development of trust in relationships.

A cognitive level of cultural competence includes being knowledgeable about diverse culturally related healthcare concepts and possessing an awareness of one's own limitations in providing culturally competent care. The best way to gain knowledge is to share experience with members of different cultures, as (Victoria 1997) suggests, "Walk a day in someone else's shoes" (Victoria 1997 P1).

The National Organisation of Nurse Practitioner Faculties' (NONPF) document on Cultural Competency identifies the characteristics associated with culture competent care (see Table 1.1)

**Table 1.1 Characteristics of health care providers who demonstrate culture competent care**

<ul style="list-style-type: none"> <li>• Does not stereotype a person, shows respect for the inherent dignity of every human being whatever their age, gender, religion, socioeconomic class, sexual orientation and ethnic or cultural group.</li> <li>• Accepts the rights of individuals to choose their care provider participate in and refuse care.</li> <li>• Acknowledges personal biases and keeps these from interfering with the quality of care provided to people of other cultures.</li> <li>• Interacts with clients from other cultures in culturally sensitive ways.</li> <li>• Incorporates cultural health beliefs, behaviours and traditional practices into the treatment plan.</li> <li>• Develops client-appropriate educational materials that address the language</li> </ul>
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and cultural beliefs of the client.

- Accesses culturally appropriate resources to deliver care to clients from other cultures.
- Assists clients to access quality care within a dominant culture.

Cited in (Green-Hernandez et al 2004).

From the above literature on culturally competent care, it is evident that any nurse or midwife demonstrating culturally competent care should not neglect the client's family. In many cultures such as the Arabic Muslim culture, important decisions are made by the family, not just the individual. Involving the family in decision-making processes and treatment plan will help to gain the client's compliance with treatment. Also, the husband or other male relative may make the final decision regarding the health care of the wife. Moreover, religion is a major issue for some cultures so this point must be addressed when delivering any educational intervention to clients.

Ultimately, culturally competent care is about acknowledgment of differences, advocacy for the marginalised and intolerance of inequity and stereotyping (Meleis 1999). The provision of culturally competent health care is a contemporary international issue that warrants further attention. Midwives must respect the health consumer's culture, value systems and ways of thinking, which is necessary to protect the consumer's rights in every aspect of care delivery.

#### ***1.6.4 Ethnicity and Ethnic Group***

Ethnicity has been defined as “a set of descent-based cultural identifiers used to assign persons to groupings that expand and contract in inverse relation to the scale of inclusiveness and exclusiveness of the membership” (Cohen 1978 p 387). Ethnicity is characterised by the common denominators of culture, language, heritage, and ancestry. Ethnicity is not a static quality that individuals possess but it is a relationship under continuous negotiation between interactants of a culture (Skutnabb-Kangas 1994 ). Ethnicity can therefore reside in cultural practices of a group of individuals. An individual's ethnicity can change over the course of a lifetime. According to Zenner (1996) ethnicity refers to a common heritage shared by a

particular group. Heritage includes similar histories, languages, rituals and preferences for music and foods.

Ethnic groups are human groups that entertain a subject belief in their common descent because of similarities of physical features or cultures, or because of memories of occupancy and migration (Smelser et al.2001.p3).

### **An ethnic group**

- is largely biologically self-perpetuating
- shares fundamental cultural values
- constitutes a field of communication and interaction
- has a membership which identifies itself and is identified by others as constituting a category distinguishable from other categories of the same order (Barth 1969)

Minority ethnic groups encapsulate the experience of social differentiation on the grounds of race, cultural difference and religion and refer to groups in the minority. Culley and Dyson (2001) assert that ethnicity is socially constructed and socially grounded in culture and is used to refer to people who share the same ancestry, religion, heritage and geography. In fact, we all have ethnicity; we are all ethnic.

It is relevant to seek an understanding of the meaning of ethnicity. It plays a vital role in the experience of Arab Muslim women in light of the September 11th attack in New York and the July bombings in London and the associated discrimination of Arab Muslims which has occurred as a result (Ken 2006 and Cainkar 2004).

### ***1.6.5 Race***

Most people think of race as a biological category and they distinguish different groups in society according to common inborn biological traits such as skin colour, eye shape, hair type, body and facial form, these being the traits that allow us to determine a person's origin at first glance. Advancing knowledge about biological variations in individuals and improving genetic knowledge bases notwithstanding, the term race remains controversial:

genetic studies have proved that there are biological differences between individuals from the same racial groups (Ahluwalia 2006). Genetic analysis of different racial groups confounds race as a biological category. Modern scientists have discovered and continue to prove that no single gene, trait or characteristic distinguishes one race from another because human beings have always been mobile, mixing genes with different populations. Genes are inherited independently. However, race is a socially constructed concept, which over time has served as a key justification for social and political interests.

Eighty five per cent of human genetic variation exists within any given population (Long 2003). Two British individuals are likely to be as genetically different as individuals from different countries.

There is much genetic variation within each race, but little between races. The main genetic differences are between individuals and not between races. Differences of genetic origin between races are not only small but also superficial. However, small genetic differences between two racial groups can lead to dramatic observable results (Edwards 2003).

Humans have been mixing for centuries and biologists have shown that we are all descendents of the original peoples of Africa (Kabasakal & Bodur 2002). In the light of this, it is easier to understand just how closely connected we all are.

Racial categories along with their definitions were constructed to support shifting political goals, specifically for the purpose of excluding certain groups. For example, in the 1900s a U.S. court decided who was legally white in order to determine naturalisation rights; these ever-shifting decisions were most often arbitrary and contradictory (Cornelissen and Horstmeier 2002).

Sandra Harding, a philosopher from the University of Southern California, has stated that race is a relationship between groups that reflects a cultural framework of societal, institutional and civilization values (Freeman 2003 P234). In science and society, race always refers to poverty, class, education, discriminatory experiences and certain behaviours, among other factors. This is despite the fact that human populations do differ and race is not the basis for these variations (Harding 1998).

After having considered the concept of race and its definition, the term will not be used in this study for a number of reasons. Race is a false classification of people that is not based on any real or accurate biological or scientific truth. Race is a political construction created by certain people for a political purpose. The concept of race was created as a classification of human beings with the purpose of giving power to white people and to legitimize the dominance of white people over non-white people. Popeau (1998 p166) suggests that the term ethnicity is typically used as a more accurate and less controversial term. Therefore this term has been used through the study.

By contrast the term racism *will* be considered. While race is a fallacy, the belief in race as a scientific category can lead to discrimination which may negatively impact on health status and on the provision of healthcare.

### ***1.6.6 Racism***

The term **racism** refers to any individuals who experience prejudice or discrimination because of their ethnic origin, religion, cultural beliefs, nationality or membership of community groups. The United Nations Educational, Scientific and Cultural Organization, UNESCO (1979 P2) stated that racism is “Any theory which involves the claim that racial or ethnic groups are inherently superior or inferior, thus implying that some would be entitled to dominate or eliminate others, presumed to be inferior, or which bases value judgements on racial differentiation, has no scientific foundation and is contrary to the moral and ethical principles of humanity” (UNESCO 1979 P2).

Culley (2006) says that racism may adversely affect health and wellbeing in many ways:

- The possibility of direct physical and psychological violence against any group perceived as “others”.
- Racism may be correlative with some exclusive practices in such areas as employment, housing, education and immigration law which negatively affects the socioeconomic circumstances of radicalised groups and thus may impact on their health.



- Unhealthy symptoms such as high blood pressure may be a clinical response to racial harassment.
- Racism may negatively affect the delivery of health care by the action of individuals who deny or delay access to health services or through health service staff providing a poorer quality of care. Karlsen justified the under-using of health services among ethnic minority people as a result of discrimination and a lack of appropriate services, and stressed the necessity of culturally competent services able to meet ethnic minority needs (Karlsen 2007).

Racism may be an aspect relevant to the experiences of Arab Muslim women.

### ***1.6.7 Religion***

Religion consists of systematic pattern of beliefs, values and behaviour acquired by people as a member of their society (Norris and Inglehart 2004). Two identifying features of religions are that they to some extent require faith, and that they seek to organise and influence the thoughts and actions of their adherents. As this investigation targets Muslim women, exploration of Islam as a religion is necessary to provide some background to the study and justify the exploration of the maternity care needs of this specific religious group.

### ***1.6.8 Islam***

Islam began in the interior of Arabia during the 7<sup>th</sup> century and was revealed to humanity by the prophet Muhammad (Ahmad 1988). It is a way of life, a system to be followed, a code of ethics and a constitution to be applied in the daily life of every person (Ahmad 1975). A basic belief of Islam is that “If any one harms others, God will harm him, and if anyone shows hostility to others, God will show hostility to him” (Al-Bukhari 1982 cited in Ahmad 1988 p10). Islam means “submission to the will of God”. In Arabic Islam and Muslim are derived from the same word meaning “peace”. The traditional Muslim greeting in Arabic is Alsalam Alaykom (peace be unto you). Islam is a religion of peace, mercy and forgiveness,

and most Muslims have had nothing to do with the terrorism which has come to be associated with the faith.

The number of Muslims is estimated at between 0.7 to 1.2 billion worldwide and 21 per cent of all people on earth follow Islam. The Organisation of Islamic Countries has 55 member states (Stodolska 2006). The moral and ritual obligations of Islamic followers are centred in the five main pillars of Islam: Shahada (confession of faith in one God, Allah), Salaat (prayer), Sawm (fasting), Hajj (pilgrimage) and Zakat (almsgiving) (Ahmed, 1988).

Religious teaching in Islam is based on the Hadith (speech) of the Prophet Muhammad, which gives meaning to living, dying, family life, childbearing, maintenance of health and causes of illness (Nahas and Amasheh 1999). The social and ethical lives of Muslims are grounded in the belief of the brotherhood of the Islamic community: everyone is of equal value. Islam governs social norms and practices as well as the legal system in Arab countries. The relevance of Islam to Arab migrant women in the UK and the potential impact of religion on health and childbirth is discussed in the findings chapters.

The increasing number of migrants to the UK from a variety of cultural and linguistic backgrounds means that maternity services must provide for a diverse range of needs of migrant women and provide care in a culturally sensitive manner. The current study investigated the experience of migrant Arab Muslim women during their childbirth in the UK. In order to contextualise the study, the following section provides information about the Arabic world.

### ***1.6.9 The Arabic World***

‘Arab’ is a cultural and linguistic term which refers to people from Arabic countries that speak Arabic and share a cultural and historic heritage (Arab American Institute Foundation 2002). The Arab world is a highly populated area of around 325 million people, a population that is expected to rise in the near future (Medea’s Information Files, 2001). Whilst the majority of Arabs are Muslims, the term ‘Arab Muslim’ has been used to differentiate this population group from the Arab Christian population who may have different values and beliefs relating to their religion. There are over 104 billion Muslims across the globe. Arab

Muslims constitute only about a quarter of the world's Muslim population. In the UK there are 1.6 million Muslims. According to the 2001 census, Muslims were the largest religious group after Christians (ONS 2001). Islamic (Shariah) law is the basis of the legal system especially in the Arabian Peninsula.

The term Arab frequently denotes the Middle East, but the greater (and more populous) part of the Arab World is located in North Africa (Medea's Information Files, 2001). The Arab world consists of 22 countries in the Middle East and North Africa: Algeria, Bahrain, the Comoros Islands, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Mauritania, Oman, Palestine, Qatar, Saudi Arabia, Sudan, Syria, Tunisia, the United Arab Emirates and Yemen. Arabs speak various dialects of Arabic and subscribe to the values and norms of Arab culture.

The earliest people of the world existed in the lands of the Arabic countries, such as Egypt, Anatolia (the land of current Republic of Turkey), and Morocco (Kabasakal & Bodur 2002). Mostly, Muslim females wear the veil and/or head-scarf, but the style of this clothing differs between Arab countries: in the Gulf region women wear long dresses and scarves to cover their body, while in other Arab countries such as Egypt, Syria, Morocco and Jordan style is greatly influenced by western fashion.

Economically, Arab countries abound in resources, particularly oil and natural gas. The Gulf is the richest area in this regard, being in the top ten oil or gas exporters worldwide. Four Gulf States, Saudi Arabia, the UAE, Kuwait and Qatar, are at the top of this range. Other Arabic countries such as Algeria, Libya, Iraq, Bahrain, Morocco, Western Sahara and the Sudan also have smaller but still considerable reserves of petroleum. This situation has resulted in significant inequalities between oil-rich and oil-poor countries, as well as extensive labour migration, especially in the sparsely populated countries of the Gulf region. On the other hand, there are immensely fertile lands in the southern part of the Sudan, an area called the food basket of the Arab world (Kabasakal & Bodur 2002).

There is socioeconomic variation not only between but within Arab countries. For example nationals of the Gulf States have extra benefits such as houses and government subsidies for such purposes as undertaking studies and getting married. Any given job even pays higher wages to Gulf States nationals than to their counterparts who have migrated from other Arab

countries for economic purposes. This leads to significant inequalities among the population of any given country. The population tends to congregate in specific localities, nationals in higher-class areas created by the government.

The adult literacy rate for those aged from 15 upwards in the Arabic world is 66 per cent, which is considered one of the lowest rates in the world (UNESCO 2007). There are significant disparities between Arabic countries, however, ranging from record low rates of around 50 per cent in Mauritania, Morocco and Yemen to moderate highs of over 90 per cent in Lebanon, Palestine and Jordan. The literacy rate is higher among Arabic youth (ages 15-24), and between 1990 and 2002 the overall rate increased from 63.9 per cent to 76.3 per cent (UNESCO 2007). All the women who participating in this study graduated from high school and some from college before their emigration to the UK.

Culturally the Arab world can be divided into five regions (Medea's Information Files, 2008)

- The Maghreb, which includes Morocco, Mauritania, Algeria, Tunisia and Libya
- The Mashriq, which includes Lebanon, Syria, Palestine and Jordan
- The Nile Valley, which includes the fertile lands of Egypt and the Sudan
- The Gulf, which includes the oil-rich states of Saudi Arabia, UAE, Qatar, Oman, Bahrain, Kuwait and Iraq
- The Bab-el-Mandeb, which includes Yemen, Somalia, Djibouti and Comoros

Arab Muslim women participating in the study came from the first four of these regions. While the Somali population was excluded from the study, they in fact form a large proportion of the UK Arab population. Although Somalia is a member of the Arab League, many Somalis identify themselves as Somali instead of Arab (Medea's information files 2001). Moreover, while Somalia joined the League in 1974 and Arabic is spoken by many Somalis in religious and educational contexts, the official language is still Somali. Moreover, the Somali population comprises ethnic Somalis with large communities of Indians, Iranians, Indonesians and Portuguese. This diversity of population has resulted in a cultural diversity compared to other Arabic countries.

### ***1.6.10 Arabic culture***

Arab nations share many societal values and practices that originate in their religious, economic, social, political, and historical circumstances. These produce a common culture distinctive to the region (Kulwicki et al, 2000). The religious ideology and societal norms and practices will be highlighted.

Arabic culture is mainly driven by three elements: family, language and religion. To understand Arabic culture we must first examine these three elements and their influence on culture. Understanding Arabic culture is especially important in the current study because it constitutes a basis for interpreting the women's experience of childbirth. In this section the role of the family and language will also be explored in detail.

#### **1.6.10.1 Family**

Arabic society is generally conservative, hierarchical and centred on the family and kinfolk, a consideration that overshadows all other demands in Arab society. The individual is seen as a part of a family, not as a separate entity. This leads to a patriarchal family structure (Nasir & Nasir 2006). Children traditionally live with their parents until they get married, and even then parents continue to provide care for their children and grandchildren. When the parents get older, the role is reversed (Endrawes et al 2007). The family structure of Arabic society is extended; it is a most durable and influential social institution. Arabic families consist largely of grandparents, aunts, uncles, nieces and nephews. Arabs mostly value family relationships highly: they meet almost daily, and share each others' happiness and sadness. The family provides stability, love, support and trust for its members. Younger people generally respect their elders, as age is considered to bring wisdom and experience. The younger generation always seeks the advice and help of a grandfather or a grandmother and appreciates their knowledge.

The dominant need among the Arab is relationships, resulting in a wide range of familial associations. Expectations in Arab society are that family members will receive constant support from friends and neighbours during illnesses and crises rather than having to cope

alone. The family forms the basis and the primary source of support for family members, whether their needs are physical, emotional or financial.

The father is the spokesperson for the family and the maker of important family decisions. The women are chief caregivers for children, the sick and the elderly. Children are privileged and parents will sacrifice themselves to guarantee that their children are well provided for. Migration thus presents a challenge to Arabic people, who must cope alone without the support of their families. This applies particularly to Arab women who endure such important events as childbirth, which require emotional and physical support from their families.

#### **1.6.10.2 Language**

Arabic is the second influential element in Arabic culture. It is the glue that binds the Arab world together; it provides Arabic society with cohesiveness, with a strong feeling of identity and a sense of personality regardless of race, religion, tribe and region (Kabasakal&Bodur 2002). Local Arabic dialects, called “Colloquial Arabic”, vary from country to country throughout the Arab world.

Arabs value their language highly because the Qur’an, Islam’s holy book, was revealed to the prophet Mohammed in Arabic. Arab speakers perceive this as the greatest linguistic achievement, and the language is consequently highly respected on religious grounds. The prestige of Arabic culture is primarily based on the language of the Islamic holy book, but the populace of Islam in general does not speak Arabic. The Qur’an becomes the standard for the written form of Arabic considered as “Classical Arabic”. The Qur’an’s message must be read in the original tongue in order to be fully understood. This religious significance accorded the language is the reason why over one billion Muslims worldwide strive to learn Arabic so as to read the Qur’an and to pray in the language in which that book was revealed.

Arabs may exaggerate and overemphasise their speech without being aware of it. Lipson and Meleis state that repetition is a typical mode of communication for Arabs. This should not be taken to mean that the speaker considers that, for example, a pregnant woman does not think that the health care professional attending her has not heard what she has said, but they want to emphasise the importance of the issue at hand (Lipson and Meleis 1983).

In conducting this research it is important to discuss the issue of women in Islam in order to obtain a true idea of how women understand and deal with any subject concerning themselves in the context of maternity services from the standpoint of their Islamic culture. Understanding Islamic tradition underpins understanding of the experience of Arab Muslim women during childbirth in the UK.

### ***1.6.11 Women and Islam in Arabic countries***

The issue of women in Islam is highly controversial. All women's rights were granted in the Qur'an and by the Prophet Muhammad. However, the situation of women in Arabia reverted to pre-Islamic norms of female subordination after the Prophet's death (Turabi 1991). Critics describe adherence to Islamic laws and norms as the source of the persecution of women in the Middle East and North Africa (Huntington 2002). On the other hand, some Muslim feminists refute this argument, referring to the complementary nature of the sexes in Islam. They also distinguish "authentic Islam" from patriarchal "pseudo-Islam". They emancipate the content of the Qur'an from the misinterpretation of patriarchal readings (Barlas 2002, Sonbol 2003). Islamist feminists have criticized Muslim family laws and customs, condemning the way they subordinate women's position in society. However, they have also refuted both patriarchal interpretations and Western stereotypes of Islam. Especially in recent decades, they have rejected the view that Islam is a fundamentally misogynistic religion, arguing instead that Islamic law has been misunderstood and misapplied, and the Qur'an's spirit has been misrepresented (Barlas 2002, Majid 2002). This will be clearly articulated by the interviewees in chapters five and six. Therefore, Islam cannot necessarily be blamed for inequalities between women and men, but this may more likely be linked to the way in which it has been interpreted by certain cultural and political groups.

In Islam, women have the same basic rights as men: the right to education, the vote and to respect. On the other hand there are some areas to which Muslim women are forbidden access: they cannot be political governors or judges. These rights, commitments, and prohibitions are grounded on divine tenets and ideas of biological and psychological differences between the sexes (Mernissi 1991). In Islam, women generally interact freely only with other women and with very close male relatives. It is not permitted for men and

women to be alone together, even for a short period of time. In Islam pregnancy is viewed as a natural condition ordained by Allah, not requiring immediate care. Childbirth is a female issue: pregnant Muslim women prefer midwives or a female physician, especially for gynaecological examinations, and abortion is forbidden in Islam even if there is a genetic defect, because such a situation is attributed to God's will.

In the Qur'an, men and women are addressed in equal terms. The Holy Qur'an says:

"O mankind, We have created you of a single soul, whether male or female, and from the pair of them scattered abroad many men and women; fear God by whom you demand one of another" (Sura Hujurat, Verse 13, p552). The issue of equality is stressed in many of the Qur'an's chapters: women are referred to as the origin of men and women. Many verses also reject the distinction between men and women, suggesting that both play an equal role in society, having an equal rights and responsibilities. Islam gives women social rights and views them as equal in every aspect of their private, social, political and economic lives. Islam gives women and men equal but not necessarily the same rights and responsibilities because men and women are viewed as similar but different. Islam never considers women as inferior to men, but maintains that their rights differ because women are not copies of men. Islam acknowledges and recognises women as self-governing individuals. In verse 194 of al-Imran (the house of Imran) God says "I waste not the labour of any that labours among you, be you male or female – the one of you is as the other" (Sura Al-i-Imran, Verse 195,p76). Discrimination, distinction and inequality are foreign to the spirit of Islam. The first supporter in Islam was a woman, Khadeeja, the wife of the Prophet Mohammed. She was also a thriving businesswoman and the Prophet Muhammed was employed by her. The first martyr in Islam was a woman: Somaya, the wife of Yasser.

The formal status of women in Islam is something unique; it guarantees woman's rights as befit her nature. Islam gives her full security and protection (Regional Bureau of Arab States 2006).

However, life for Arabic women can be quite different from the spirit of Islam. Arabic women have suffered from socio-cultural factors limiting their ability to achieve success in developing their status and role in society. In traditional Arabic societies women are still closely defined by motherhood, whereby childrearing and household duties predominate



(Minces 1992). The Arabic woman achieves high status by bearing children, especially sons. The caring of children is carried out in the feminine world of the mother and other females in the extended family. The father has little practical participation in this issue as it is seen to contradict masculinity. The role of the male in Arabic societies is to be the family guardian and breadwinner. The patriarchal cultural values which contradict Islamic values have subordinated women and encouraged gender inequality; as a result there is discrimination against Arabic women in the private and public spheres. Women are expected to be obedient to the spouse and are deprived from attaining family and civil rights (Benhadid 2005). Traditional discriminatory attitudes towards women, affect Christian as well Muslim women in Arabic countries.

There is then, an important distinction to be made between the ideals of Islam as a religion and the lived experience of women in Arabic culture. Statistically Arabic women are more disadvantaged economically, politically and socially compared to women in countries at similar economic developmental stages or with similar income levels such as countries in Latin America and Southeast and East Asia (Human Development Report Office, 2004). All Arab countries have in place a structure of family law that awards women the status of dependents and minors regarding marriage, divorce, child custody and inheritance. Women were originally affiliated with their family roles, and a kind of “patriarchal gender contract” predominates in Arabic region.

The degree of gender inequality and second-class citizenship for women varies among Arab countries (Kabasakal and Bodur 2002). Nowhere in Arabic countries have women enjoyed equal rights and opportunities with men. However there are considerable variations in women's political rights, civil rights, family law, and access to education and jobs among Arabic countries. For example in Lebanon, Syria, Jordan and Egypt, women, particularly those who are educated, have very active roles in society, while women's roles are greatly restricted in the Gulf States (Sidani 2005).

That the situation of women differs between Arabic societies is due to the role of culture, as well as to the radical interpretation of Islamic teaching which has influenced its followers in various ways. In the twentieth century, an Arab woman's right to education or participation in public life was not recognised (Al-Faruqi 1987). This led to the birth of several feminist movements in the first decades of that century. The first one began in Egypt in 1919 and

spread to other Arab countries including Syria, Lebanon and Iraq (Sidani 2005). As a result women have recently advanced in social and economic development (Regional Bureau of Arab States 2006). They have started to work alongside men in all fields of work, but the extent of their participation still varies between countries. While restrictions on the practice of women's rights was relaxed in some states such as Egypt, Lebanon, Syria, Iraq and Jordan, other countries including the Gulf States prohibited women from participation in economic and political life. According to the Arab Human Development Report (2002) women's participation in politics and economics remains minimal, and there are indicators of considerable gaps in gender equality (Baroudi 2004). Social class produces further differences among women in these countries.

Islam is not a set of beliefs and rituals but a social order that affects every aspect of a Muslim's corporate life (Sidani 2005). This thesis will therefore explore both the religious context of Arab women's lives and the cultural environment in which they live.

## **1.7 Organization of the Thesis**

This Heideggerian hermeneutic study investigated the experience of migrant Arab Muslim women during the period of their childbirth in the UK. The participants in this study shared their experiences with the researcher. While each recollection was distinctive, shared meanings soon emerged, and these produced major themes that allowed the researcher to derive an interpretative phenomenological text articulating the meaning attributed by the women to their experiences.

This thesis is divided into seven chapters. I have chosen to start this introductory chapter by illustrating significant aspects of how I became interested in this research topic. I then reflected on my own philosophy that underpins this study, identified the study's aims and introduced key concepts. This chapter provides readers with a starting point from which to understand the Arabic world in general and the influence which Islam and Arabic culture may have on the lives of migrants. It has also examined the position of women in Islam and suggested that, contrary to formal Islamic teaching, false radical interpretations

of Islam and prevailing cultural norms may result in the subordination of women in Arabic societies

Chapter Two reviews the literature that explores maternity services and ethnicity. It commences with a brief overview of factors impacting on the health status of people from minority communities. The strategy used to search electronic databases is then described. Due to the limited number of studies examining the childbirth experiences of Arab Muslim women in Western countries, the literature on ethnic women and childbirth is reviewed in general, and gaps are identified. Studies of the potential barriers and factors that might restrict access to and use of maternity health services by ethnic minority women are examined in detail, and their findings critically analysed and discussed. Potential barriers are grouped into five categories, language barriers, socioeconomic status, racism, cultural and religious insensitivity, and losing social support.

Chapter Three introduces a description of Heideggerian hermeneutic phenomenology, which is the methodological approach chosen for this study. The chapter commences with the debate between positivist and subjectivist traditions. Following this, an overview of the various philosophies behind qualitative research is presented, and the decision to choose phenomenology over the others is justified. The two types of phenomenology are highlighted, and the reasons given as to why ontological-hermeneutical phenomenology is the most appropriate approach by which to reveal the meanings migrant Arabic Muslim women give to their childbirth experiences in the UK. Finally, critiques of hermeneutic phenomenology are examined and the researcher's awareness of the dangers of exceeding the limitations of this approach is made clear.

Chapter Four discusses the steps used in conducting this study, starting with the obtaining of ethical approval and ending with the presentation of the results. The criteria by which participants were included and the procedure used to recruit them are laid out. The data collection method of the interview is discussed, as well as the reasons why the semi-structured interview is particularly suited to this study, after which a detailed description of the interview settings is given. My role as a researcher in the research process is discussed. The interviews were conducted in Arabic, then transcribed and translated in English; this process of transcription is illustrated. The method of coding interviews in the NVivo 2 program is explained and the steps used to analyse the data (steps based on the guidance

offered by Smith's (2003) approach of interpretive phenomenological analysis (IPA) together with the principles of Gadamer (1975) are described. Problems of achieving rigour in the conduct of a hermeneutic research study are discussed, including the steps used to achieve reflexivity and validity.

Chapter Five, the first findings chapter, deals with the women's idiographic experiences. It introduces the women and their backgrounds. Their experiences are presented as individuals, or "parts", which are then related to the "whole" as it is linked to the methodology underpinning this study. The significant sentences, perceptions and meanings embodied in those idiographic experiences (the parts) are related back to the whole in thematic analysis to reveal shared meanings. The experiences are presented in the order in which the women were interviewed.

Chapter Six discusses the shared meanings of those experiences through thematic analysis. Six main themes emerged from the data: displacement and reformation of the self, by the Grace of God, the vulnerable woman, adaptation to the new culture, dissonance between two maternity health systems and the valuable experience. Each of these themes incorporate a number of sub-themes. Extensive quotations from the women's interviews support the interpretation of the data. The six main themes represent an ontological description of what it means to be a migrant Arab Muslim woman experiencing childbirth in the UK.

The final chapter, Chapter Seven, discusses the overall findings of the study and relates them to the relevant literature by comparing and contrasting the participants' viewpoints with previous work on the subject, thus clearly articulating the study's original contributions to the body of literature in this field. The implications of the findings for health and social care including clinical midwifery practice are discussed, and suggestions for further research outlined. The limitations of the study are then presented.

## **CHAPTER TWO**

### **ETHNICITY AND MATERNITY SERVICES**

#### **2.1 Introduction**

Prior to the 1950s Britain was a relatively ethnically homogeneous society, although there has been a presence of people of Caribbean, South Asian and African origin in Britain for many centuries. In the post Second World War period larger scale migration to Britain occurred, largely in response to labour shortages (Fryer 1984). Recent decades have seen social patterns of migration change due to increased internationalism. In addition to the ‘settled’ communities of South Asian, African and African Caribbean origin, Britain has received significant numbers of migrants (both permanent and temporary) from many parts of the world (Watt 2004). Immigration makes a society more culturally varied, and the resulting diversity of cultural, religious and healthcare needs presents challenges to health care providers. This chapter will outline the ethnic make-up of Britain and discuss briefly the competing explanations for ethnic health inequalities in general. It will then review in more detail the existing literature on ethnicity and maternity care, which provides the background for the current study.

The 2001 the UK census indicated that minority ethnic groups form around 7.9 per cent of the total UK population (4,694,681 out of a total population of 58, 84, 8579). The Office of National Statistics records indicate that 50 per cent of the minority ethnic community in the UK gave their ethnic origin as Asian or Asian British, 25 per cent black or black British and a further 15 per cent as mixed race (ONS 2001a). The 2001 Census data show that the ethnic minority population is growing more rapidly than the indigenous population: approximately 73 per cent of Britain’s overall population growth was due to a high birth rate and to migration. A higher fertility rate among several migrant groups and the larger proportion of the population being of childbearing age means that there is a significant demand for maternity services (National Evaluation of Sure Start 2005). This may challenge health care providers, who need to address many aspects of each individual’s life when planning and

providing care, including consideration of their physical, social, emotional, intellectual and spiritual wellbeing (Meleis 1999).

## **2.2 Ethnic Differences in Health Status**

The health status of minority ethnic groups in the UK appears to be worse compared to the white majority population, although there are important differences both between and within minority ethnic groups (Culley and Dyson 2005). Although minority ethnic groups experience the same range of illnesses as others in the UK, there is a tendency of some within ethnic minority groups to report worse health than the general population and an increased prevalence of some specific conditions (Sproston & Mindell 2006). Coronary heart disease and diabetes, for example, are up to five times more prevalent among South Asians, and three times more prevalent among people from African and Caribbean backgrounds (Randhawa 2007).

There are many difficulties in interpreting the relationship between ethnicity and health (Culley and Dyson 2005). Explanations for ethnic health inequalities remain contested and there are several theories that may explain patterns of health among minority ethnic groups. Culley and Dyson (2005) briefly explain some of the factors and mechanisms whereby ethnic and social status may impact on health status. Several of these factors may be relevant in contextualising the experience of Arab Muslim women in this study.

### ***2.2.1 Genetic Factors***

The concept of distinct races is rejected by all scientists, but genetic factors as an explanation of health variations among ethnic groups cannot be ignored. As we have seen, some diseases are more dominant in some ethnic groups. However, a recent comprehensive review of the evidence produced by the London Health Observatory, demonstrated significant differences *within* minority groups, which suggests that simple genetic or indeed cultural explanations for ill health are unlikely to be an accurate explanation for why some minority groups experience more illness than others (Aspinall and Jacobson 2006). Alternative explanations for this

disparity include migration, racism, accessing services, socio economic status and cultural norms.

### ***2.2.2 Migration***

There are higher levels of ill-health among migrants than among the population as a whole. Evidence from the 2004 Health Survey for England revealed that 15 per cent of Bangladeshi men reported their health to be “bad or very bad” compared to 6 per cent of men in the general population (King’s Fund 2006). However, the evidence does not suggest that levels of ill-health are caused by the process of migration or by previous poor health. Singh and Siahpush (2002) show that some immigrant groups have better health profiles compared to US-born groups; this advantage reflects a combination of healthier lifestyles in the country of origin and the selective migration of healthy immigrants. However it has been reported that with longer US residence, immigrants lose their health advantages as a result of increased risk-taking behaviours (poor diet and exercise), the loss of social support systems and cultural conflicts (Singh and Siahpush 2002). This argument is further strengthened by the work of Williams (1993) who suggests that increased length of time in Britain increases the level of poor health amongst migrants (cited in Culley and Dyson 2005).

### ***2.2.3 Racism***

Several studies have identified significant degree of racism in British society, though the impact of racism on health has been historically under-researched. However, there is growing evidence that racism can affect health in several ways:

- Racism in health service provision and delivery.
- Indirect effect of racism by immigration laws, implementation of social security systems and racism in housing, employment and education.
- Possible direct effect of racism in creating internalised anger and in raising blood pressure. Karlsen (2007, p2) proposed that “experience of racist verbal abuse or physical violence is related to a greater risk of premature death; high blood pressure; respiratory illness; lower self-esteem and life satisfaction; psychological distress, depression and anxiety; suicidal tendencies; stress and anger; psychosis; and more work-limited long-term illness and disability”.

### ***2.2.4 Access to Services***

The evidence base on access to healthcare services has been hampered by inadequate ethnic data collection in the NHS (Westminster Primary Care Trust 2008). However, there is some evidence to suggest lower overall levels of satisfaction with services by minority ethnic groups, and there are some significant problems in accessing and receiving high quality healthcare. Aspinall and Jacobson (2004) found inequities in access to health services related to communication problems, insensitive and incompetent cultural care, racism and insufficient resources and services in inner city areas. In addition, people from ethnic minority populations have reported difficulties such as long waiting and short consultation times when seeing their GPs; these difficulties leading to dissatisfaction with the outcomes of consultations. Also, minority ethnic people have pointed out that their preferences regarding the provision of care providers who are compatible in gender and ethnicity are not being met.

### ***2.2.5 Materialist Explanations***

There is a strong relationship between socio-economic status and health. Taking socio-economic disadvantage into account, in part explains the differences in health between ethnic minorities and the majority population (Williams 1999). Nazroo (2003) suggests that social and economic inequalities underlie the problem of ethnic inequalities in health. He maintains that socioeconomic status is a main determinant of health and lifestyle and influences the use of health services. This was further strengthened by a Health Survey Report for England which suggested that health is commonly poorer in lower socioeconomic groups (Department of Health 2004).

Many people from minority ethnic communities experience poverty, which correlates closely with ill-health. The Bangladeshi and Pakistani communities, for example, experience high rates of deprivation and have the worst reported health (Nazroo 2003). Although evidence suggests that socio-economic disadvantage is a very important part of the explanation for ethnic health inequalities, it does not entirely explain it. Additional factors, such as racism, difficulties of accessing healthcare and some aspects of cultural difference are also likely to play a part in determining health status (Kings Fund 2006).



### ***2.2.6 Culture***

Some health care providers perceive minority ethnic communities as dangerous to their own health as a result of culturally based attitudes towards health. Culturalist explanations however have been heavily criticised (Culley 2001). Ahmed 1996 refuted the idea that health behaviour is constructed according to culturally based health beliefs. He highlighted diversity in health beliefs and behaviours within same cultural groups. He also illustrated how the differences of socioeconomic status produce different health care experiences (Ahmed 1996). The role of cultural differences is often over-emphasised, but that is not to deny that culture can be an important dimension in people's interaction with healthcare services.

This necessarily brief discussion has demonstrated that ethnic inequalities in health generally, are likely to arise from a combination of factors. Socio-economic deprivation is clearly of considerable importance, but that is not to say that issues of culture and the inadequate response to cultural difference on the part of service providers is unimportant. Racism, both individual and institutional, has also been found to be of some significance in explaining ethnic health differences.

The NHS has recognised health inequalities among ethnic minority groups and has implemented various initiatives to attempt to provide accessible health care for all people living in the UK regardless of their ethnicity or cultural background (Department of Health 2005). The government's rationale for action on ethnicity and health is laid out in the Department of Health's Race Equality Scheme (DHRES) 2005-2008 (Department of Health 2005). The NHS have emphasised the creation of a service with more responsibility to all patients' individual needs. The DHRES states that "the NHS increasingly needs to take into account not only cultural and linguistic diversity but also needs to be able to cater for varying lifestyles and faiths" (King's Fund 2006 p1).

The Department of Health accepts that some ethnic minority groups experience poor health in comparison with others due to inequalities in accessing health services (Department of Health 2005) and is committed to reducing the "satisfaction gap" and ethnic inequality related to access. Policies specifically relating to maternity care will be discussed later. The chapter now turns to a more detailed discussion of the existing literature on ethnic differences in

maternity services and the potential implications of this for the experiences of Arab migrant women.

## **2.3 Maternity Services and Ethnicity**

The World Health Organization (WHO) proposes that maternal health may best be understood as a state of physical, mental and social well-being (Mooney et al 2008). In the human reproductive process, which includes pregnancy, childbirth and puerperium, the physiological process is the same for females around the world (Braithwaite et al 2004). As a result of differences in social circumstances, as well as culture, religion and values, prenatal, childbirth and postnatal care practices vary greatly in different societies and cultures. Moreover, the experiences arising from migration such as isolation, absence of kinship and support networks, together with poor English skills, create social disadvantages in accessing maternal health care services for this group, which have been linked to numerous poor maternal health outcomes (Alcorse and Schofield, 1992). This is supported by a study conducted on Somali refugee women in an area of west London, which indicated unequal access to maternity services by this group of women due to lack of interpreter services, stereotyping and racism from health service staff, and a lack of understanding by staff of cultural differences (Harper-Bulman and McCourt 2002). Mackinnon and Howard (2000) assert that lack of language skills and uprootedness were the two issues causing most emotional distress. They further highlighted the importance of social support in providing protection from mental and physical illness, especially during stressful events like immigration.

A national survey of women's experiences of maternity care found that there was disparity in the way care was provided to, or experienced by, women, particularly in those from minority ethnic groups (Redshaw et al 2007). The Healthcare Commission's investigations into the maternal deaths of ten women at North West London Hospitals Trust indicated that nine of the ten women were from a minority ethnic background (Health Care Commission 2007). The report "Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer 2003-2005", released by The Confidential Enquiries into Maternal Health (CEMACH), indicated that women from some ethnic minority groups are at three times more risk of maternal death compared to white women (Lewis 2007). Furthermore 25 per cent of women

from ethnic minority populations access maternity services when they are five months pregnant or more or they miss four or more routine antenatal visits during their pregnancy (House of Commons 2003). The NHS Plan published in 2000 asserted that the health of mother and baby during childbirth will build the foundation of the baby's health throughout its life, and gave evidence that the mortality rate of Pakistani female children in their first year of life was twice that of children of women born in the UK (Department of Health Public Services Agreement 2000).

## **2.4 The Process of the Literature Review**

A selective literature review was continuously employed throughout this study. The aim of the literature review was to find any papers which explored childbirth with ethnic minority women. As part of this review, national and international sources were accessed. Literature across the many disciplines involved in the childbirth experience (midwifery, nursing, medicine, social sciences and healthcare) over the period from 1985 to 2009 was reviewed. The initial strategy was to search electronic databases using the terms. The databases searched included:

- Medical Literature on Line (MEDLINE)
- Maternity and Infant Care (MIDIRS)
- British Nursing Index (BNI)
- Applied Social Sciences Index and Abstracts (ASSIA)
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- Websites, including the Department of Health and the Office of National Statistics

The literature search revealed very few studies which specifically included Arabic Muslim women so although the focus of the present study is migrant Arab women in the UK, the literature review includes research literature about women from Pakistan, India, Bangladesh, Thailand, China, Turkey, Somalia and the Middle East, who share a minority ethnic status and in some cases the status of immigrant, with the women who participated in this study. It was assumed that some of the generic issues which these studies revealed might also be of relevance to the women who are the specific focus of this thesis. See table 2.1 for the electronic database searched and terms.

**Table 2.1 The electronic database searched and terms**

<b>Key Terms</b>	<b>MEDLINE</b>	<b>MIDIRS</b>	<b>ASSIA</b>	<b>EBSCO (included BNI and CINAHL)</b>
<b>Ethnicity and maternity services</b>	<b>160</b>	<b>1685</b>	<b>94</b>	<b>5</b>
<b>Arab Muslim women and childbirth</b>	<b>4</b>	<b>1663</b>	<b>5</b>	<b>1</b>
<b>Migrant women and childbirth</b>	<b>24</b>	<b>1681</b>	<b>36</b>	<b>3</b>
<b>Language barriers and ethnicity health</b>	<b>113</b>	<b>9349</b>	<b>532</b>	<b>6424</b>
<b>Cultural and religious childbirth beliefs</b>	<b>35</b>	<b>1</b>	<b>62</b>	<b>2921</b>

A review systematically undertaken of the citation titles and available abstracts indicated considerable overlap. Some of the literature turned out not to be relevant to the disciplines of nursing and midwifery; this applied specifically to articles with keywords found in the abstracts, but with childbirth experiences not being discussed in the body of the paper. After reviewing the citations, the final list of titles was divided into groups according to the study's objectives and the subheadings of the literature review chapter.

The following section discusses the factors emerging from the literature regarding the difficulties facing migrant women when they attempt to access maternity services.

## **2.5 Problems and Issues Facing People From Ethnic Minorities During Childbirth**

As indicated previously a considerable amount of literature highlighted that people from ethnic minority groups are likely to experience many difficulties in their contact with health

services in the UK (Ali and Burchett, 2004; Harper-Bulman and McCourt, 2002; Katbamna, 2000;) and elsewhere (Ny et al, 2007; Rolls and Chamberlain, 2004; Liamputtong, 2001; Wiklund et al,2000). The challenges revealed by this research amount to an intensification of the suffering that migrant women experience in their everyday lives.

Jenny McLeish, Social Policy Officer at Maternity Alliance indicated two forms of inequality in accessing maternity services. The first concerned inequalities in physical access and knowledge of the services available. The second occurred through ethnic minorities receiving poorer quality care (House of Commons Health Committee 2003). McLeish also argued that women from south Asian backgrounds are late in accessing maternity services and make fewer antenatal visits. Moreover, Asian women received 70 per cent fewer antenatal screening tests such as those for haemoglobin disorders and Down's syndrome compared with white women.

Communication is a particularly important aspect of effective maternity care because it is an essential ingredient of every other aspect of care giving. Good communication helps patients understand and interact confidently in their care plans, and helps healthcare providers offer information and support for clients in a timely and appropriate manner.

### ***2.5.1 Language Barriers***

Language barriers can decrease women's satisfaction regarding the quality of care they receive during the prenatal, labour and childbirth stages. One study undertaken with migrant women in Australia reported migrant women did not take an active part in decision making regarding their care in labour and birth because of the communication problems they experienced (Small et al 1999). Jayaweera et al (2005) found that childbearing Bangladeshi women who were more fluent in English felt they received higher quality care in the UK maternity services. This was supported by the findings of Richens (2003). In this study one woman who learnt to speak English between her first and second pregnancy, felt that the attitude and behaviour of midwives was more positive in her second pregnancy. However this could also have been linked to her familiarisation with the maternity services available.

Harper-Bulman and McCourt (2002) demonstrated that language barriers are one of the factors that prevent Somali refugee women gaining equal access to maternity services. This

argument was further reinforced by the work of Davies and Bath (2002) who researched Somali women in a Northern English city. They indicated that poor communication skills were a fundamental cause of poor access to maternity services.

In 2003 a qualitative study was conducted into Muslim parents' experiences of maternity services in England. The study found that there was poor communication between healthcare providers and Muslim parents, and linked this to a shortage of interpreters for those who did not speak English (Ali and Burchett 2004). This confirmed the findings of an earlier study which compared the experience and satisfaction of Asian and non Asian patients with non clinical aspects of their hospital care (Madhok et al 1992). This study highlighted how Asian patients in England were at risk due to poor access to trained interpreters. Ali and Burchett (2004) also criticised the over-reliance of NHS staff on family members or friends acting as interpreters, and highlighted the lack of accessible and easily comprehensible information during childbirth for Muslim women. The UK government promised free translation and interpretation services for all NHS trusts by 2003 through NHS Direct (DOH, 2000). However, the availability of interpreters remains patchy (Aspinall and Jacobson 2004).

Failure in communication has been identified as an important focus of complaints. A review of 47 published articles examined the relationship between language barriers and health disparities among ethnic minorities. The results indicated that language problems were linked to a lack of awareness of the benefits of healthcare, as well as an insufficient use of health services and dissatisfaction with health services (Yeo, 2004).

The use of family members to act as interpreters was mentioned by many patients as a major concern because of the issue of confidentiality. In one study conducted in London, the participants stated they still used their children rather than friends for interpreting because they did not want other people to find out about their health or family problems (Kensington, Chelsea & Westminster BME Health Forum, 2002). The majority of participants did not know about NHS Direct or its provision of language facilities. Others complained that healthcare providers were not proactive in offering interpreting services – in fact, they were very unwilling to provide them. In one case, an elderly Arabic woman asked the receptionist for an interpreter only to be told that interpreting services were unavailable and it would be better for her to register with an Arabic GP. Some patients reported that they missed their appointments because they could not find their way to clinics, and how it would be helpful if

signage in hospitals was multilingual. Many women discussed the subject of faulty communication in maternity services. For example, having never had the role of the health visitor explained to them, they thought their visits were only for the purpose of vaccination. They also did not understand the purpose of checkups in antenatal clinics, and some consequently did not attend these. Many women were not informed about antenatal classes (Kensington, Chelsea & Westminster BME Health Forum, 2002).

Harper-Bulman and McCourt (2002) observed a higher level of satisfaction when interpreters were used in the maternity care of non English speaking women. The problem was, however, that many midwives did not use the services even when they were available. This study emphasised that language support was the single most important factor for Somali women, and how providing translation services had a positive impact on all aspects of their care. At the heart of the women's comments was they had no option but to use their children as interpreters despite the fact that they were aware that it was often inappropriate to discuss issues of maternity with them. Moreover, women had to take their children out of school on the day of the follow-up visit to interpret. Sometimes women missed their hospital appointments because they could not find an interpreter to accompany them. On a more positive note, Somali women who received more continuity of care from midwives built good relationships with them. The midwives listened carefully to them and explained everything, making every effort to overcome the language barrier.

### ***2.5.2 Socioeconomic Status***

A study by Jayaweera et al (2005) of Bangladeshi childbearing women in the UK showed how disadvantaged socioeconomic status affected women's satisfaction with care. Most women who participated in the study lived in deprived, overcrowded areas, and most were working in semi-skilled or unskilled jobs. Some of them did not have the means to pay for transportation to access care. Findings also showed how the impact of the new baby adversely affected their financial status.

In England 2003-2005 the data revealed that women who lived in most deprived areas were around five more time likely to die in comparison with mothers who lived in the least deprived area (Lewis 2007). Moreover the babies delivered to these group of mothers were 108 times more likely to die perinatally than other babies (Confidential Enquiry into Maternal

and Child Health 2008). Women who were refugees, asylum seekers or newly arrived migrants had the highest rate of maternal mortality compared to white women. For example Black African women had the highest rate (62.4 vs. 11.1). Black Caribbean women exhibited the second highest maternal mortality rate (41.1), followed by Middle Eastern woman (32.0) (Lewis 2007).

Black and minority ethnic women experienced problems in maternity services due to their socially and economically marginalised status (Fisher 2008). Several studies addressed that the support and entitlement system did not provide adequate food or shelter for asylum seeker pregnant women and mothers (McLeish 2002, Penrose 2002).

While some Arab people living in the UK are from educated middle class backgrounds, it must also be acknowledged that others are from lower socioeconomic groups, especially those from Morocco and Algiers. Socioeconomic status and experience may be linked to satisfaction and experience of maternity services in some migrant Arab Muslim women though there is limited research available in this area to date.

### ***2.5.3 Racism (Discrimination and Stereotyping)***

Muslim women in general may have special needs which health care providers may need to consider. In a study exploring antenatal care and prenatal testing of Muslim women in Australia (Tsianakas and Liamputtong 2002), it was highlighted that Muslim women faced prejudice when accessing maternity services. Study participants explained how wearing the hijab (the traditional head scarf worn by Muslim women to cover their hair) created many difficulties for them, not least of which was that health providers assumed they could not speak English because of their physical appearance. Moreover, the women complained of a lack of respect and negative treatment by staff. One participant had a nursing background and was very knowledgeable in this area, despite which she perceived that she was treated negligently, as a migrant woman (Tsianakas and Liamputtong 2002). Such prejudice has been long established. In a study over 15 years ago Asian women who were not fluent in English were characterised as unsympathetic, demanding and unintelligent by the UK maternity services (Bowler 1993). It is difficult for women with poor English skills to build a personal relationship with their midwives and therefore refute the assumptions made about them.



It is the right of every pregnant woman, whether native, foreign-born or migrant, to have equal access to maternity services and be treated equally by those services. Ellis (2004) maintains that maternity services are in fact designed for white middle class women. She supports her argument by discussing how antenatal classes designed for couples might exclude Muslim women precisely because they include men. Participants in a study conducted in London insisted that they would not attend antenatal classes because the presence of males made it culturally inappropriate (Kensington, Chelsea & Westminster BME Health Forum, 2004).

Allport (1954) defined stereotyping as making imprecise judgements about a person based upon the presumed features of the group to which that person belongs. Cross-Sudworth (2007) explored the concept of stereotyping by seeking the opinions of midwives regarding women of foreign ethnicities: they expressed the view that such women were 'difficult', that they needed a large amount of time to deal with and that they were a further drain on an already over-taxed service. These inaccurate assumptions not only affect communication, they also lead to a poor standard of maternity care.

Health care providers' possible stereotypical beliefs may adversely affect service delivery. McLeish (2002) found that racism negatively affected communication between midwives and women. This is echoed by Richens, who reported an incident in which a Pakistani woman was asked many times by a receptionist to act as an interpreter for women who looked Asian but did not speak the same language as her (Richens 2003). Davies and Bath (2001) likewise found that Somali women received inappropriate maternity care due to the negative attitudes held by healthcare providers.

The Maternity Alliance report (2000) suggested that people in general, including health staff, see Muslims as 'different' and 'dangerous'. Several women in Ali and Burchett's study (2004) complained of discrimination in maternity services, a situation that had become worse in recent years because of fears about Islamic fundamentalist terrorism. The Muslim women interviewed highlighted stereotypical racist views held by healthcare providers. Women's complaints were perceived by staff as 'Asian woman syndrome'. Many women said how staff belittled their doubts and concerns, asserting that they were exaggerating, wasting time and complaining about minor problems in order to get help. Similar findings were reported in a paper by Kensington, Chelsea and Westminster's BME Health Forum (2002). The

participants' view was that staff often preferred other patients over Muslim ones and it was viewed that these prejudices became more pronounced following 9/11.

Stereotypical assumptions support the view that Asian women are 'all the same'. It is argued that midwives use such stereotypes to make decisions about the type of care different women need, which creates inequalities in the provision of maternity services for women from ethnic minorities (Bowler, 1993). In a survey conducted by the West Midlands Institution, women said that pain relief methods were not discussed with them antenatally, while hospital midwives said that Somali women were 'more natural', and they seldom requested epidurals, preferring 'gas and air', and that they like to be directed instead of receiving information and choices relating to their care. This is a clear example of cultural stereotyping by midwives (Harper-Bulman and McCourt 2002).

Tinkler and Quinney (1998) conducted a study on the impact of the midwife-woman relationship on women's perceptions of maternity care, and how this relationship is clearly important in ensuring satisfaction. Magill-Cuerden (2007) argued that the concept of respect is an essential factor in any communication or interaction between human beings.

#### ***2.5.4 Cultural and Religious Insensitivity***

Diversity in the cultural and religious beliefs between the Muslim population and health care providers creates challenges in accessing health services. These difficulties are not simply about language problems, but also involve people's concepts of health and disease, life and death. Health providers particularly need to understand the diverse array of customs and beliefs, to ensure they provide the best inclusive care. Consideration of diversity in beliefs will enhance the establishment of a trusting relationship between care providers and patients. The literature suggests that traditional and cultural practices are highly relevant during childbirth (Wiklund et al, 2000). However, giving birth in a foreign land is a real challenge for migrant women, who allude to limited access to traditional practices and social support (Hoang et al 2009). The problem lies in the ignorance of health providers of the traditional preferences of migrant couples. Brathwaite and Williams (2004) argued that culture will heavily influence peoples' behaviours and their choice of treatment, yet their study suggests that many health staff have limited knowledge of the influence of culture on health status. The beliefs and practices of Arab Muslim women may therefore be an important issue to

consider when they access maternity services. A better understanding of migrant childbirth beliefs may result in more effective maternity care.

In a study conducted in Australia which explored Thai women's childbirth experiences, the women complained of the different beliefs and practice system. They followed the instructions given by their carers because they were afraid to defy the dominant culture with the Australian health care system (Liamputtong 2000). In another study in the UK Muslim parents expressed concern about privacy during childbirth, and how they experienced embarrassment and discomfort because of the lack of privacy (Maternity Alliance 2000). Tsianakas and Liamputtong (2002) demonstrated that women's dissatisfaction with maternity care arose not just from language problems, but from a lack of cultural awareness among health care providers. For example invasive prenatal testing such as amniocentesis is routinely offered to all women over 35 years. The staff assumed women would accept this regardless of their social and cultural context. Secondly, the importance to Muslim women of their doctor's gender. Whilst Islam is a flexible religion: to save a women's life, she can be seen by a male doctor if a female one is not available, male doctors can be consulted if it is really needed, but many Muslim women prefer to consult a female doctor. In Tsianakas and Liamputtong's (2002) study unavailability of female doctors led women to refuse prenatal testing. Also the women expressed that they had negative experiences because of staff insensitivity regarding Islamic beliefs. The gender preference issue was also explored by Lowe et al (2007) who reported how one Pakistani woman missed her appointment when she thought an intimate examination would be performed by a male doctor, and another woman was surprised by the sudden involvement of a male doctor during the insertion of an intrauterine device and refused to complete the procedure. Such beliefs may be shared by other Arab Muslim women and it will be explored in this study, whilst acknowledging that beliefs and behaviours of Pakistani women may not necessarily reflect those of Arab Muslim communities.

The studies discussed above draw attention to the importance of staff considering women's beliefs when giving care, considering more than the clinical care itself. In addition, they highlight the need to individualise care to meet ethnic and cultural expectations. Lavender stressed the necessity of greater cultural understand among midwives in order to achieve this (Lavender 2003). This study will add to this body of knowledge raising awareness among midwives of the need to offer culturally relevant care to women from different backgrounds.

### ***2.5.5 Losing Social Support and Social Isolation***

Migration creates isolation and stress especially for women who migrate from communities where family and relatives provide social support (Nahas and Amasheh 1999). Kinship in many societies is a vital matter at the time of childbearing and childrearing. In migration those support mechanisms will not be available. Even relationships between people from the same ethnic background will change in a host country. In other words, migration leads to different interpersonal relationships from those in the homeland. This may in part be due to anxieties of uprooting and the desire to adapt to life in a new country.

Strong feelings of isolation and need for kin support were experienced by both Somali women and men who migrated to Sweden. They described their life in Sweden as "an immense loss of status, both socially and economically". The findings of this study illustrated that migrants are vulnerable to psychological stress, as a result of language barriers, limited social networks, and cultural conflicts (Wiklund et al, p108, 2000).

A large scale study was conducted in Australia with 318 Vietnamese, Turkish, and Filipino women, who were interviewed 6-9 months after giving birth. The aim of the study was to investigate migrant women's personal views about the factors causing depression following childbirth. Most of the women identified isolation and being homesick as the most important issues in their experience (Small et al, 2002).

Another transcultural study described the perceptions and meanings attributed to care by Jordanian women living in Australia who had experienced postpartum depression. The findings showed that new Jordanian mothers who had migrated to Australia experienced severe loss of control as a result of feelings of loneliness and hopelessness and the guilt of being a bad mother. The women stated that care means strong family support and kinship in the postpartum period; it is the ability to fulfil such traditional gender roles as mother and wife; and it involves the perpetuation of cultural practices regarding childbirth. The study suggested the Jordanian migrant women are at risk of postpartum depression because they are accustomed to living in big households where extended families provide physical and emotional support during childbirth, while after migration feelings of isolation and loneliness

are intensified during pregnancy and postpartum, at just the point when family support is much needed (Nahas and Amasheh 1999).

The realisation that poor maternal mental health during childbirth can have serious results for individual women, their partners, babies and other children is confirmed by Government policy (Department of Health 2004). Women who suffer from postpartum depression have a higher risk of continuing or recurrent depression (Forman et al 2000). Postpartum depression has also been linked to the negative effects of early infant development. Serious consequences for children include increased risk of accidents, sudden infant death syndrome, and in general a higher incidence of hospital admissions (Forman et al 2000). Many studies have investigated the relationship between maternal mental wellbeing and birth outcomes. One study in Brazil measured the psychological stress and distress of 852 pregnant women between 30 to 36 weeks of pregnancy. The findings revealed an adverse association between maternal distress and intended breastfeeding duration (Rondo and Souza 2007). Another study investigated the link between maternal distress/ depression during pregnancy and the development of childhood sleep problems. The level of maternal distress/depression was measured using the Edinburgh Postnatal Depression Scale. The findings revealed a clear association between the level of maternal distress and depression and problematic childhood sleep behaviour (Armstrong et al 1998).

Discussion of the seriousness of postnatal depression and its consequences shows that the responsibility for early screening and detection of maternal distress in vulnerable women falls on midwives, who can increase antenatal support and prepare the couple for the impact on them of becoming parents. Ingram and Taylor have developed an assessment tool that midwives can use with pregnant women during antenatal care, that identifies those at risk of developing postpartum depression (Ingram and Taylor 2007).

In this section, the literature dealing with minority ethnic populations and maternity services has been discussed. There is limited research relating specifically to migrant Arab woman's childbirth experience, supporting the need to investigate these women's experiences in detail. Good communication and cultural sensitivity play an enormous part in delivering high quality care to the migrant populations, particularly in maternity services. In this field there are a number of research papers that explore and explain the problems faced by health professionals (Abu-Enein et al 2006; Small et al 2002) but there is little published work

documenting what Arab Muslim women feel about maternity services and whether or not they are satisfied with their care. The woman during her pregnancy needs special attention from her health care providers and her family. The migrant Arab Muslim woman will be under more pressure because of the absence of her normal social support structures and her experiences living in a country where she may have communication difficulties. She cannot seek advice from older women in her family, as often happens in Arabic societies. The gap could be partially filled by midwives providing information and answering a woman's questions and also encouraging and supporting women to develop new social support networks in the communities in which they live.

One of the key studies conducted in the UK exploring the experiences of women from ethnic minorities accessing maternity services in the UK was that of Yana Richens (2003) on Pakistani women's experiences of childbirth. This study in particular helped me in my research. It was the first study I had seen on this subject, and it dealt mainly with women whose religion was the same as that of the participants in my study. It provided useful knowledge of some of the difficulties facing migrant Muslim women in the UK during and after their pregnancies. On closer examination, I discovered that Richens concentrates on her participants' shared social and religious values and, instead of investigating the differences between them, attempts to make her results representative of all Pakistani female migrants to the UK. It is perhaps because of this collective focus that she omits to provide detailed backgrounds of each of her participants. Consequently, she cannot investigate the effect of their historical, social and economic circumstances, or the intensity of their religious beliefs, on the meaning they attribute to their experiences. It is crucial here to state the obvious: each woman is an individual; no two women are alike. The Pakistani population, like any other, is diverse, and from a nursing or midwifery point of view care needs be individualised for the Muslim woman undergoing childbirth, as well as her family .

The literature search conducted for this thesis reveals that only one study has investigated patterns of communication between health care providers and Arab Muslim women in maternity services in the UK (Davies and Papadopoulos 2006). The aim of the present doctoral study is to provide health caregivers in the UK with basic cultural knowledge of Arab Muslim women. The findings show how the experiences of individual Arab Muslim women and individual caregivers come into conflicts with a system of maternity services whose cultural frame of reference conflict with what they themselves constructed. The

findings pertain to the cultural values attached to labour pain and the dangers associated with the acceptance of medical advice about decisions to make use of various methods of intervention. A further pattern relates to the use of scans and information about potentially hazardous effects on the child, forms of information that may be used to construct maternal identities.

In order to explain the findings, Davies attempts to show how accounts of labour pain among Arab Muslim women were used to present cultural identities (Davies and Papadopoulos 2005). The results illustrate that both direct and indirect experience of labour pain prepares women to take responsibility for their labour and birth. The study also shows that the role of pain is to prepare women for ownership of their children and initiation into motherhood. Finally, labour pain is regarded as a private issue for the immediate family only; sharing the experience outside the family threatens the cultural and religious guidance of the child.

The second finding of Davies' study reveals how Arab Muslim women believe the mother's emotional state has a crucial effect on the wellbeing of the foetus. They therefore follow specific practices intended to protect them from distress during pregnancy. But, when dealing with UK maternity services, it is difficult to avoid distressing topics. Information concerning screening, risks to the child and particularly the possibility that the foetus is abnormal is provided by maternity health caregivers. Receiving this information is perceived to create a real danger to the pregnancy. The interviewees told of how they were torn between ignoring the medical advice on potential harm and acquiring medical knowledge which might offer them reassurance. In cultural terms, the provision of such information during pregnancy was regarded as restricting women's abilities to preserve embodied agency (Davies and Papadopoulos 2006).

The present study will explore a wider range of women's experiences and all the dimensions of difficulties encountered by women during their childbirth, and to suggest ways to improve maternity services for this group of women, rather than concentrating on a specific aspect of care, as in the study carried out by Davies.

## **2.6 Conclusion**

This chapter lays the foundation for an understanding of the experience of Arab Muslim women in childbirth. We have seen that ethnicity and health are closely related and that minority ethnic groups in the UK experience poorer health than the general population, although there are important differences between and within groups. The chapter has briefly discussed the interacting factors which help to explain ethnic health inequalities in general and has highlighted in particular, significant issues surrounding the experience of minority ethnic women in accessing and experiencing maternity services. The literature suggests that ethnicity can impact on maternity experiences in several important ways. However, the experiences of migrant Arab women have only been explored in the context of one UK based study, and it is argued that a more detailed exploration of the experiences of this group will not only provide evidence for improving services for Arab women, but may also suggest lessons for improved care for minority ethnic women and families more generally. The next chapter will discuss the methodology chosen for this study and the rationale behind that choice.



## **CHAPTER THREE**

### **METHODOLOGY CHAPTER**

#### **3.1 Introduction**

The overall aim of this study was to gain ontological insights into the experience of migrant Arab Muslim women during their childbirth in the UK, and to provide a descriptive, interpretive account of that experience. The choice of research methodology began with a consideration of the debate between the positivist and subjectivist traditions. This was followed by an exploration of the subjectivist paradigm and a justification for the selection of a subjectivist approach for this investigation. Having chosen subjectivism, a number of methodological approaches were evaluated and phenomenology was chosen. Finally, an in-depth exploration of phenomenology was undertaken and Heideggerian Hermeneutic phenomenology adopted. This chapter explores the philosophical and methodological background to these choices according to the framework just outlined, and critically evaluates the resulting selections.

#### **3.2 Choosing An Inquiry Paradigm**

An exploration of research philosophy and methodology was undertaken to identify an appropriate means by which to investigate the aims and objectives of the study.

There are broadly speaking two approaches in collecting information for research purposes: quantitative research methods (based upon positivist principles) and qualitative methods (based upon post-positivist principles).

##### ***3.2.1 Positivism***

Positivism is a philosophy developed by Auguste Comte in the second half of the 19<sup>th</sup> century. The emphasis in this paradigm is on knowing the fundamental laws governing matter. It contends that genuine knowledge is founded on sensory experience, such as knowledge emanating from the postulation of theories through precise scientific methods, and that the

acquired knowledge should be confined to the natural, physical and material worlds. Auguste Comte argued that all true knowledge comes from individual observation of objective reality; this true knowledge must be gained from objective, discernible, and measurable data. Any other transcendental knowledge should be rejected (Crossan 2003).

The aim of quantitative research is to describe the types of knowledge generally associated with the natural sciences; it claims that there are objective facts ‘out there’ which need to be discovered by rigorous enquiry, resulting in universal laws of cause and effect (Arksey and Knight 1999). Positivism uses standardized instruments for data collection such as questionnaires, because there are some fixed ideas regarding the subject under study.

While this positivist, scientific method has dominated the natural sciences, it has been challenged. A major criticism of this approach is that it cannot examine human behaviour in a deep way. Sociologists contend that human behaviour is complex, that it changes over time and that it is difficult to predict in different circumstances, so it should not be explained by rigid social laws (Crossan 2003). Positivism when used in this sphere yields useful but limited data that only provides a superficial view of the phenomenon under investigation.

The aim of this study is to gain ontological insights into the experience of migrant Arab Muslim women during their childbirth in the UK. In seeking to gain a deeper understanding of these women’s experiences, the limitations of a positivist quantitative approach were recognised. Specifically, experiences of childbirth are relative to individuals and their contexts: there will be differences in thoughts, feelings, behaviours, practices and levels of fulfilment. The positivist approach cannot deal with this variety of results because it does not provide an explanation for or an understanding of the diversity of women’s experiences. Another limitation related to the “measurement” of women’s experiences is that these cannot be explored and described in terms of objective data that are not quantifiable (feelings, anxiety, satisfaction) and translated into statistical form. Humans are not objective, and their behaviour, feelings, perceptions and attitudes are subject to many influences that positivists would reject: they cannot capture women’s experience holistically and meaningfully from a reductionist perspective. There is no experimental control for women who are being investigated in their normal environments. The need is for an approach that gives a richly detailed description of women’s experiences, collected from women by analysis of their

words rather than by numbers. This consideration leads to the search for another paradigm to achieve in-depth understanding of women's childbirth experiences.

When social scientists took the methods that had been successful in the natural sciences and applied them to human affairs, the results were inadequate; these unsatisfactory results were blamed on methodological inadequacies (Arksey and Knight 1999). These findings could only be explained by studies that were not adequately controlled. Consequently, social scientists became aware of individual differences and peculiarities, and started to give accounts of human thoughts, feelings and actions, recognising that no prediction can be applied to all individuals. Alternative, post-positivist philosophies (qualitative or subjectivist paradigm) fill the gap created by the adoption of methods originating in the natural sciences that could not be applied to the human sciences.

### ***3.2.2 Post-Positivism***

Post-positivism is the alternative tradition of positivism. It also overlaps with terms such as anti-positivism, subjectivism and interpretivism. The philosophy of post-positivism is the discovery of people's feelings, opinions and experiences from their own point of view rather than from that of the researcher, in order to gain understanding at the individual or group level, and the enhancement of understanding rather than a superficial exploration (Clarck 1998). It claims to describe life from the participant's viewpoint (Hoepfl 1997), a method that accords with the aim of this study. Vishnevsky and Beanlands (2004) also maintain that the qualitative method with its focus on exploration of individual experiences from a holistic, detailed perspective provides a valuable device for generating and testing new hypotheses.

As this study aims to explore those aspects of culture that influence the experience of maternity care as well as the personal experiences of participants, a qualitative approach is most appropriate. "Qualitative research attempts to increase our understanding of why things are the way they are in our social world, and why people act the ways they do" (Hancock 1998 p1).

One of positivism's key advantages relates to the observer's independence of the object of enquiry. This is opposed to post-positivism's roots in the researcher's subjective perceptions, as these are considered to be an element in the inquiry itself (Flick et al 2004). Critics have regarded this as one of the limitations of post-positivism, arguing that such studies would be

strongly influenced by researcher bias because the researcher would be too closely identified with the study, and that other researchers would therefore come to different conclusions (Crossan 2003). The second limitation is the highly subjective nature of the paradigm. It is unique to its setting, and is therefore not replicable – replicability being a key element in validating research.

There has been much recent debate over the issue of quantitative versus qualitative research methods in nursing and health care research. Rapport and Wainwright (2006) argued that the purpose of much nursing research is different from that of medicine. The former is more orientated towards healing than curing, and is thus grounded in the patient's experience, which is not amenable to empiricist approaches.

This study is concerned with the childbirth experiences of migrant Arab Muslim women; the researcher felt that a detailed picture of the experience was needed. This could be obtained by inviting women to describe their experiences freely and without inhibition or constraint. Such considerations led the researcher to adopt a qualitative approach to collecting verbal accounts of women's experiences; the study is concerned with such accounts rather than with testing preconceived hypotheses. Quantitative methods miss this emotional dimension, which is essential to the experience. Measurement, categorisation and statistical analyses are inadequate tools with which to obtain a holistic understanding of a woman's experiences. The nature of this study necessitated the use of a qualitative research methodology, because it is also useful in understanding the experiences of women in their social context.

In recent years, researchers have increasingly engaged in qualitative rather than quantitative methods, especially in the areas of sociology, psychology, cultural studies, education, economics, nursing and public health (Flick 2000). Holloway (2001) states that over the last 10 years, qualitative research has become more acceptable in nursing and midwifery research in particular.

Within the post-positivism paradigm the term qualitative research encompasses a number of research methods that differ in their theoretical assumptions, their understanding of the object and their methodological focus. The specific methodology used in this study was chosen from among several that were considered.

### 3.3 Choosing A Methodology

A diverse set of techniques and philosophies are included in qualitative research.

The three approaches of grounded theory, ethnography and phenomenology were considered as potentially relevant to this study. Their superficial similarity in their aim of describing what happens in any given situation posed a challenge to the researcher in making a choice between them, as each one promised to offer a relevant means of exploring the experiences of childbirth for migrant Arab Muslim women. A brief discussion follows regarding the reasons for the ultimate rejection of grounded theory and ethnography in favour of phenomenology.

#### *3.3.1 Grounded Theory*

Grounded theory was developed by two sociologists, Glaser and Strauss, who elaborated on the theoretical framework of symbolic interactionism. **Symbolic interactionism** means that individuals expound their experiences and create meaning out of them through the symbolic significance assigned to those experiences.

The goal of Grounded Theory is to generate theories grounded in reality from inclusive explanations of phenomena (Glaser and Strauss 1967). By collecting and analysing data the researcher needs to be sensitive to relevant material; this is called “theoretical sensitivity”. The grounded theory process is complete when no new ideas emerge from the data. This point is called “**theoretical saturation**”.

This approach focuses on unraveling the elements of an experience. By studying these elements and the links between them, a theory is generated. This enables the researcher to present an understanding of the nature and meaning of that experience for a group of people in a defined situation (Strauss and Corbin 1990).

The aim of this study was to understand the essential meaning of women’s experiences in context through careful description of those experiences. This involved endeavoring to understand experiences rather than providing an explanatory framework. Grounded theory was therefore rejected because this study requires a methodology which allows for the experiences of Arab Muslim women to be explored and understood rather than explained. In

order to comprehend this experience, there is no need to generate theories or models to explain the phenomenon being investigated. There is however a need to understand the meaning in women's experiences, as opposed to predicting, interpreting and explaining behaviour.

### ***3.3.2 Ethnography***

Ethnography is a methodology often used in descriptive studies to gain more knowledge of cultures and people within those cultures. The goal of ethnography is to discover and describe the ethics, beliefs and practices of specific cultural groups. The researcher needs to interact with the participants and participates in their social settings during the study period (Ploeg 1999). Ethnography emphasises the importance of the researcher's immersion in the data through fieldwork and observation. The researcher then interprets the data resulting from the participants' own viewpoints, and the results of this interpretation are expressed through the participants' own words, using local language and terminology to illustrate the phenomena (Hancock 1998). The data collection methods are participant observation and in-depth interviews, which are time-consuming because the researcher needs to spend a long time in the field.

The result of ethnographic inquiry is cultural description of the kind that can only be gained from a lengthy period of intensive study and by living in the subject's social setting. Investigators must observe and participate in at least some of the activities that occur in that setting. Most critically, they depend heavily on working extensively with a few participants.

Ethnography specifically focuses on how individuals are influenced by the culture in which they live and how they interrelate within their cultural group. While this study indeed explores the experiences of Arab Muslim women who may share cultural norms, other factors may influence their experience. Using an ethnographic perspective would therefore limit what the study could possibly explore to cultural factors, thus unacceptably narrowing the investigative range of women's experiences. For this reason it was rejected as a methodology.

### ***3.3.3 Phenomenology***

“Phenomenology” is derived from the Greek words “phenomenon”, meaning “showing itself-in-itself”, and “logos”, meaning “reason” (Heidegger, 1962 p54). Heidegger extended his explanation of phenomenology and defined it thus: “Phenomenology is about making manifest what one is talking about in one’s discourse” (Heidegger, 1962 p54). Phenomenology is an approach that entails investigating and describing the phenomenon in its precise meaning for the individuals who experience it. It is the study of phenomena; it is an approach of thinking about what the life experiences of people are like (Sokolowski 2000).

Phenomenology emerged at the end of 19<sup>th</sup> century in order to solve the crisis in the human sciences, when positivism proved incapable of dealing with the questions asked in that field (Sadala and Adorno, 2002).

The phenomenologist assumes that being human is both significant and motivational because of people’s self-awareness. The expression “being in the world” is a concept that acknowledges that people have physical ties to their surroundings – they think, see, hear, feel and are conscious through their bodies’ interaction with the world (Polit and Beck 2006). In brief, the study of phenomenology can be described as the study of human experience and the way we come to understand our everyday world. Phenomenological thinkers describe the structure of experience and pose questions regarding existence and meaning. It is concerned with an individual’s personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself (Smith 2003). Lavery (2003) characterises phenomenology as belonging to the life world or the experiences of humans as they live them. It is of central importance to show the mundane aspects of these experiences.

The phenomenological approach has been chosen for this study because it allows the exploration of the human experience through contact with people in their natural environments, thus generating rich, descriptive data that helps gain an understanding of their experiences and attitudes (Rees, 2003, P375). The methodology aims to help understand the world in which we live and why things are the way they are. It is concerned with the social aspects of our world (Maykut and Morehouse 1994).

This study is based upon the principles of phenomenology, as it aims to generate a deep understanding of the experiences of migrant Arab Muslim women during their childbirth. It will allow study of these experiences from the women's point of view and will assist the researcher to explore and describe their meaning to the deepest degree. Such findings may in the future inform sensitive and effective midwifery care for this group of women. The study focuses on the meanings, including those that are initially hidden, of their experiences. In this study the researcher's role was to understand, uncover, reflect on and interpret migrant Arab Muslim women's reality and the context in which this reality existed by entering their lived world during the time of their childbirth in the UK. Through listening to and understanding the meaning attributed to these experiences, which reflected their needs, the using of the phenomenological approach helped reveal the participants' needs, hence improving midwifery practices as they pertain to care of this group of women.

There is a new trend in health and social care regarding a need to understand user experiences in health services (Todres and Holloway 2004). The phenomenological approach has become more popular in midwifery and nursing research as a viable alternative to the investigative methods used in the natural sciences. It is obvious that phenomenological inquiry adds to the development of empirical, moral, aesthetic, personal and socio-political knowledge. It is concerned not with evolving predictive and prescriptive theory but with articulating the nature of human experience.

There are two main phenomenological approaches used in qualitative research that must be taken into account in order to attain such an understanding, these being known as Husserlian and Heideggerian phenomenology. The following sections begin by discussing individual aspects of Husserl's and Heidegger's philosophies and goes on to explain some of the philosophical underpinnings of phenomenology and hermeneutics, before concluding with a discussion of ways in which Heideggerian phenomenological thought has been incorporated into the methods used in this study.

### **3.4 The Philosophy of Edmund Husserl**

Edmund Husserl (1859-1938) a German philosopher, was credited with the initial development of phenomenology as a philosophy, when he introduced the term



“phenomenology” in his book *Ideas: a general introduction to pure phenomenology* in 1913 (Moran 2005). Husserl criticised positivist approaches that used methods appropriate to the natural sciences without observing that the objectives of social science research were different. Husserl’s notion offered an alternative to positivism by replacing statistical data for personal descriptions with casual connections by which the lived experience could be interpreted (Sadala and Adorno, 2002). He described phenomenology as a recurrence of the lived world, the world of experience. He was concerned with revealing the essential qualities of phenomena as they appear in their context and how they arise.

Husserl linked the phenomenon and being in a coherent way. He argued that a phenomenon exists when a being experiences it. The Husserlian tradition is epistemological in that it studies phenomena as they appear to consciousness. When he developed the concept of the ‘life-world’, he sought an answer to the question ‘How do we know?’ by describing the world as experienced by people. Husserl’s interest was in using the ‘life-world’ as a source of evidence for enquiry. ‘Life-world’ refers to empirical happenings or events that we live before we know (Todres and Holloway 2004). He investigated the way that subjects know objects and asked whether the object of consciousness has an existence discrete from us, concluding that what matters is not the ontological existence of an object but the realisation that that objects exists in our consciousness (Rapport 2001).

Husserl described the phenomenon rather than explaining it, highlighting phenomena as they reveal themselves, as they translate to the world of experience rather than to any objective reality. The source of any knowledge is grounded in experience, which is pre-reflexive. He emphasized the importance of understanding or comprehending the meanings of human experience as it is lived (Husserl 1970).

Husserl argued that to successfully engage in the phenomenological method three interlocking factors must be taken into consideration: phenomenological reduction (epoche), description and search for essences.

Phenomenological reduction, ‘epoche’, or transcendental reduction refers to the process by which reduction of the consciousness is achieved. In bracketing, the researcher must suspend any assumptions regarding the participants’ experiences. The aim of the bracketing process is to inhibit or restrain the researcher’s own assumptions and explanations of the data (Husserl 1970). Bracketing is ‘essentially a first-person, self- reflective process’ (Crotty 1996 p60).

All the researcher's beliefs must be laid aside and all pre-knowledge concerning the phenomenon under study are neither confirmed nor denied. Through the 'epoche' process the researcher is encouraged to describe the object exactly as it felt, a process that needs 'free imaginative variation' (Rapport 2001). Husserl's goal in 'epoche' was to see things as they are through intuitive vision in order to achieve successfully contact with the essence of the phenomenon.

Husserl's philosophy aimed, through suspension of any assumptions, to achieve the 'intuition of essence' by a state of individual pure consciousness which involves the investigator being totally isolated from the external world. He claimed that 'a new way of looking at things' is essential. For Husserl, essences are 'a priori', basic and authentic structures of meaning that underpin all knowledge. The researcher experiences the phenomenon exactly as it is in consciousness, and its description takes place without construction, interpretation or explanation (Husserl 1970).

From Husserl's viewpoint, the researcher attempts to establish the interview subject's view of reality. The participants use their own logic in relation to this reality and their memory of experience, excluding any outside influence or researcher management. For Husserl, bracketing is one element in an 'essentially first-person, self-reflective process', in which Husserl invites us to engage so as to achieve lucidness and ascertainment (Crotty 1996). Husserl wanted the researcher to stand apart from the study so that they could describe the phenomenon exactly as it is, without contamination by the researcher's preconceived notions. Such bracketing has been challenged, Smythe explained that the challenge of bracketing is in recognising our thoughts, perceptions and feelings in order to use them as a kind of reflector when faced with a view of the phenomena. By taking these biases to the data and by showing them to the reader, the researcher acknowledges the absurdity of setting aside our preconceptions because they are with us when we are faced with any new situation (Smythe 2000).

In this study I consider my pre-understanding as an advantage. The factors (my concepts, principles, beliefs and adherence to Arabic Muslim culture) I have in common with the participants in this study constitute the starting point for me to understand their experience of childbirth. In bracketing my pre knowledge I cannot articulate the inner meaning of the experience, as I know the impact of every word in the women's experience. This accord with Crotty's (1996) reasoning that "if we all have preconceptions and presuppositions, how can

we avoid imposing such presuppositions and preconceptions on the data” (p19). He suggests that bracketing involves the investigator’s reflection on their past and present experiences, together with the segregation of the meaning of those experiences from those of the participants. The purpose of bracketing for Husserl is to make it possible for the researcher to concentrate on the participants’ experiences, to permit participants to construct and give meaning to their own reality, and to give the researcher the ability to enter their lived world and to explore it fully. During the interview process I attempted to clear my mind to the best of my ability, and not to direct the women to talk about specific issues from my own point of view. When new issues emerged from the conversation regarding my general questions about the experience of childbirth in the UK, I explored those I felt to be relevant. At the commencement of the study my pre-understanding was frequently called to mind as I reflected on the data represented in the women’s interviews: they offered a superficial understanding of the women’s lived experience, an insight that was deepened as the study progressed. It was difficult for me to achieve the rigor of Husserlian philosophy during the research process. Sometimes the women were not aware to talk about relevant aspects of their experience, and they needed only a little indirect encouragement from me to explore some matters that they deemed essential to the theme of the study. I found that there was no way Husserl’s philosophy could provide a realistic basis for my activity: if it is hard to expect anyone to suspend their own everyday conceits, judgments and understandings, it is impossible to do it with someone else – or with their data.

In this research my pre-understanding will be the starting point for this phenomenological study and I will identify my assumptions rather than rid myself of them. My preconceptions reinforce the basis of my understanding of the women’s’ experiences. I have not used them to shape the data collection process, and I have not used my own assumptions to construct the data. On other hand I was challenged by my pre-understanding in a different way: sometimes I did not realise that issues I took for granted were relevant to other people from different cultures like midwives in the UK. When my supervisors read the transcribed interviews, they picked on these issues because of their different perspectives. For example, all Arabs view blood as profane, and in their interviews, the women frequently referred to their annoyance at their babies not being bathed immediately after delivery in order to clean the blood off. I assumed that this was a cultural and religious norm for all people, but my supervisors viewed it from a different perspective.

Husserl's philosophy will thus not be adopted because my aim was to profit from my interpretive pre-understanding and enrich my understanding of the women's experience through a full explanation of the interview text from the viewpoint of Arab Muslim women, a viewpoint totally different from that of midwives living in a different culture. The need for another philosophy that allowed my background to be used in the research process led me to adopt Heidegger's approach.

### **3.5 The Philosophy of Martin Heidegger**

Martin Heidegger (1889-1976) was born in Germany and began his studies in theology rather than philosophy. Heidegger was a student of Husserl and he considered himself first as an Husserlian; Husserl tutored him in the process of phenomenological intentionality and reduction. Heidegger became proficient in his mentor's teaching. Husserl acknowledged that he had found his heir, and he supported Heidegger's succession to his professorship at Freiburg University. Once Heidegger had assumed that position, he proceeded to distance himself from his mentor's work. Heidegger was concerned for the nature of 'being', his tradition leaning on an existential perspective. He shifted the philosophical focus of phenomenology from Husserlian epistemology 'how do we know what we know?' to Heideggerian ontology by studying the nature and relations of being 'what does it mean to be a person?' (Lavery 2003).

Heidegger criticised Cartesianism for introducing epistemology into ontology, the latter being his basic concern. He characterised it as "what it means to be a person and how the world is intelligible to us at all", as opposed to epistemology, "the relation of the knower to the known, i.e. how we know what we know" (Benner 1994 p43-46). While epistemology seeks to discover what can be known about the world, ontology concerns itself with what exists. Heidegger renounced the subject-object schism and directing attention to the ontological condition that involves the understanding of being rather than the relationship of the knower to the known (Heidegger 1962). Heidegger was concerned with the meaning of lived experience and existence, and for this reason Heideggerian phenomenology is sometimes referred to as existential phenomenology.

In Heideggerian phenomenology it is critical firstly to discover what it means to be a person, the answer to which will determine how a research question is asked and answered. The goal of Heideggerian phenomenology is to reveal ‘the nature and meaning of being’. This essential element of Heidegger’s philosophy “Being and Time” will be discussed in the following section.

### ***3.5.1 Being and Time***

*Being and Time* (1927) is Heidegger’s seminal work. It is an impressive analysis of human being, or *Dasein*, the German term Heidegger prefers to use. *Dasein* is translated as ‘the mode of being human’ or ‘the situated meaning of a human in the world’ (Lavery 2003). *Dasein* is not an object but a happening, and by connecting it to time it can be linked to a life journey. *Dasein* also means ‘being there’; “existence”. The world is “out there” and *Dasein* is the human being in that world. The world is not, however, a geographical place but a personal world, inherent in the self. Heidegger admits that there is “a definite ontical way of taking authentic existence, a factual ideal of *Dasein*, underlying our ontological interpretation of *Dasein*’s existence” (Heidegger 1962 p 358). He also depicts the real existence consideration of *Dasein* as only a presupposition with reference to the theme under study. The presupposition is *Dasein*, the theme is being. He added that we are thrown into a world rich in knowledge and understanding, and we are constantly engaged in skills and pursuit to understand ourselves as subjects and give meaning to our world and our lives. These functions remain in the background and cannot be freely articulated because they pertain to every life function, even our use of language. They and their workings can, however, be represented to those who share those assumptions. To understand the phenomenon we need to use our historical background to reveal the underpinning meaning. Being in the world involves a continuous state of interaction, and the accumulated experiences acquired in everyday life build the personalities by which we observe phenomena. By our pre-knowledge we try to understand our life world. It is illogical to try to understand any experience while denying all our past knowledge and presuppositions.

The concept of ‘Being-in-the-world’ has a precise application in understanding the experience of migrant Arab Muslim women during childbirth in relation to Heideggerian phenomenology. It became obvious that women’s’ existence at maternity services creates meaning. In this study, migrant Arab Muslim women referred to *Dasein*. Women ‘are there’

when they access maternity services in the UK, so they are ‘being-in-the-maternity-services-in the UK’ as part of their world. Understanding of these women’s existences can be gained through interpretation – but not description – of meaning. It is necessary to understand ‘the essence of being a migrant Arab Muslim woman’ to interpret the hidden meaning in the experience. The assignment here is “to explain Being itself and to make the Being of entities stand out in full relief” (Heidegger 1962 p49).

Husserl and Heidegger disagreed in their approach to how to explore the lived experience. Researchers have therefore concentrated on differentiating between Husserlian and Heideggerian doctrine when highlighting the methodological approach for a phenomenological study (Rapport and Wainwright 2006). This includes highlighting the degree to which there is the possibility of suspending pre-understanding and assumption. The two philosophers argued about the possibility of suspending assumption through reduction (*epoche*). Husserl stated that researchers should suppress their natural attitudes or suspend naturalistic presuppositions concerning knowledge, instead focusing on “clarifying the essence of cognition” (Husserl 1964, p18). Heidegger countered this by saying that researchers are already in the world, and that it is impossible to categorise ourselves. He argued that, being in the world, researchers interact with others, not as observers but as beings cognate with, indeed of the same world as, that which is observed (Heidegger 1962). In contrast Husserlian philosophy rejects the presuppositions and prejudices of the researcher and the existence of an underlying shared order.

In this study I found it quite difficult to make my everyday understanding totally explicit because I believe that the function of our background is to understand ourselves as beings and to make sense of our world and of our lives. Through my own background as an Arab Muslim woman who has migrated to the UK, my understanding of the life context of my compatriots who have undergone the same experience is enhanced. My background will constitute the basis for an articulation of the hidden meaning of these experiences, as I am a member of this society and know for myself what it is to give birth in these circumstances. My interpretation of this experience will be totally different from that of a person who comes to it with a mind clear of any pre-existent knowledge of those circumstances. I was aware of the need not to impose my interpretation or perspective on these women’s experiences, so I described and interpreted the data from their own perspective. This will appear in the analysis chapter, which assures reliability partly by including the subjects’ codes of interviews.

Heidegger contradicts this position by maintaining that pre-understanding is already with us in the world, and that it cannot be put aside. Nothing can be encountered without reference to a person's background understanding, and the subconscious attitude is integral to knowing. Therefore, bracketing is impossible because we are always interacting with the world (Rapport and Wainwright 2006).

### ***3.5.2 Heidegger's Analysis of Being***

The research question of this study was: what does it mean to be a migrant Arab Muslim woman and have childbirth in the UK?. By adopting Heidegger's philosophy, it is central to inspect his analytic of Being. In Heidegger's philosophy, he appreciated the essential nature of the three elements of language space and time to comprehend and gain understanding of what it "means to be". These elements provide a context in which experience takes place; without understanding the participants' contexts, the stories would not be completed.

#### **3.5.2.1 Language**

Language is a medium of communication. It differentiates human beings from other life forms, and it demonstrates people as being-in-the-world. Heidegger asserted that language is not word, but 'way of speaking'. It mirrors the state of mind and the inner mood of being, so revealing something about the individual (Heidegger 1962 p205). He emphasised that through language we are concerned with speaking and listening to the unspoken; he regarded silence as a source of speech and the real meaning behind it. Therefore silence is an active part in conversation and has a voice that can reveal important meanings in discourse.

When language is used to direct attention to a problem it is called "articulation". In this research the participants permitted me to enter their world by articulating their stories and allowing me to share their experiences. The knowledge gained permitted me to arrive at a realization of reality, a procedure supported by Heidegger's assertion that language is the articulation of reality (Heidegger 1962).

The concept of language is very important in this study, as it allowed me to reveal the women's reality. It was very useful that the participants and I shared the same language, and that all interviews were conducted in Arabic. I was aware of each silence, each exclamation

such as “ahhh...” and the placement of each pause for breath, and the body language in general. I interpreted the hidden meaning of all of these signs in order fully to understand their experiences.

### **3.5.2.2 Space**

Space refers to the context of the study. An understanding of experience can be achieved by paying attention to the subject’s feelings, thoughts and pursuits. Heidegger’s expression “referential totality” means the interpretation of everyday life activity within its context, which is shaped by the culture and the circumstances in which people find themselves in space. Space is a reflection of a person’s real world (Heidegger 1962).

In order fully to understand the women’s experiences, we must first know the context of their lives. Their feelings, thoughts and beliefs during childbirth can be revealed by locating them in the context of their countries, and discovering how Arabic Muslin culture plays numerous roles in these experiences.

### **3.5.2.3 Time**

People live in a changing world. Time gives meaning to a person’s existence. Heidegger refers to time as historical. The past, present and future all influence peoples’ ways of experiencing an event. People’s lives change over time, a state of affairs that results from their existence in a temporal context. The past is known; people acknowledge that it is out of their control but that it still influences their present state of being, and allows them to possible future existences (Heidegger 1962). In this study, the presence of the women’s past experiences “previous deliveries in their own countries” remains to shape their present ones “delivery in the UK”; these may in turn modify the memory of the past. Perspectives on the future may also be coloured by past and present experiences.

These observations have helped me shape the understanding of the nature of the ontological world that is the focus of this inquiry. This is why I have used concepts relating to Heideggerian phenomenology to inform the present study.

Heidegger’s notion attracted my attention because it is well situated as a methodology to study migrant Arab Muslim women’s experiences of childbirth in the UK. The challenge lies in seeing and recognising what must eventually be brought to light. I brought knowledge of such experiences to the research question, because I had myself delivered in a foreign,



although still Arab, country, and the memory of that event was still fresh for me. Through contact with the participants in the study I gained further insight into the lived experience. In using Heideggerian phenomenology I tried to establish an engagement with the women's world and to increase the richness of my experience. This required that I note some of my own experiences and knowledge before the commencement of data collection, in order to see later how the interpretation would develop.

The methodology used for this study is driven by Heideggerian hermeneutic phenomenology. The terms "interpretive" and "hermeneutics" are used interchangeably. The researcher seeks to understand the phenomenon through its participants' narratives – that is to say, the researcher engages in an interpretive process. Interpretation is an attempt to bring to light the hidden meaning so as to obtain a comprehensive understanding. It is proposed here that understanding is more powerful than explanation for prediction in the social sciences (Benner 1994). The interpretation must be audible and plausible and provide a greater understanding of the phenomenon under study. Heideggerian phenomenology relies on an interpretative approach: he himself used the term "hermeneutics" to explain the interpretive process. Hermeneutic phenomenology is construed as the means of explaining and describing experience by using phenomenological reflection; this will be explained in the following section.

### **3.6 Hermeneutic Phenomenology**

As mentioned before, the terms interpretive and hermeneutical are equivalent. Hermeneutics is an esthetic found in early Greek thought. It suggests the gaining of understanding, a process involving language. It was originally used to interpret biblical texts to reveal God's message hidden there. In the early 19 century Schleiermacher (1768-1834) redefined hermeneutics as the study of understanding itself (Palmer 1969). Dilthey (1833-1911) identified hermeneutics as the core of those disciplines that aimed to interpret expressions of the inner life of human beings (Palmer 1969). In the early 20<sup>th</sup> century Heidegger proposed that interpretation is a fundamental mode of human beings (Heidegger 1962).

Heidegger proposed that there is no way of 'objectively' knowing anything about the world: all knowledge comes from people who are already in that world, and who seek to understand others in it. People are engaged in a ceaseless process of understanding. Researchers and

informant share practices, interpretations and everyday practical understandings by merit of their common cultures and languages. Furthermore, people are fundamentally self-interpreting beings. Comprehending human action always implies an interpretation. This interpretative approach is called hermeneutics. The goal of hermeneutic interpretation is to understand the lived world of experiences, and to find the commonalities in meaning, skills and practices embodied in them.

Hermeneutic phenomenology does not require that procedures be used in practice. What it does demand is the acquisition of thoughtful, reflective and attentive practice by articulating the meaning of lived experiences and achieving a sense of understanding (Zalm 2000). Thus, hermeneutic science involves the art of reading a text so that the intention and meaning behind appearances are fully understood, a state of being achieved through the expressive-mantic style in the phenomenological text. Van Manen (1997) maintains that a perfect phenomenological text is one that leads us suddenly to see that ‘something’ in an expression that will rich our understanding of the experience of everyday life (van Manen 1997).

Hermeneutic phenomenology (HP) has both a descriptive and an interpretive essence. Heidegger stated that “phenomenological description, as a method, lies in interpretation”(Heidegger 1962 p61). Van Manen (1997) explained this notion by arguing that the primary objective of HP is to explore and describe a phenomenon as experienced in real life by using phenomenological reflection to produce an account that understands the form the phenomenon takes (Manen 1997). It explains the internal meaning or essence of the person’s experience by providing understanding rather than a casual explanation of that experience. Van Manen adds that interpretation takes place through the discussion process, as it describes aspects of experience in the text or interview protocol (Manen 1997). Interpretation reveals what is hidden behind the objective phenomena. The phenomenological text has the power to detect the world as we live in it; it articulates experience through language and gives it its full value.

Reflective interpretation of a phenomenon is required in order to gain a comprehensive and more meaningful understanding. The reflective-interpretive process not only involves description of the experience as it appears in consciousness, it also needs an analysis of the underlying aspects and discerning interpretation. Rapport and Wainwright (2006) agree with Schleiermacher (the creator of the hermeneutic circle in 1833), that interpretation by means

of understanding is acquired through continuous re-examination of assumptions. Thus the final interpretation is regarded as only tentative rather than absolute or true.

In the hermeneutic approach the researcher must engage in a process of self-reflection in which his or her biases and assumptions are not bracketed or set aside but rather embedded as integral to the interpretive process. Interpretation therefore depends on the researcher's perspective. Different meanings may be ascribed to the same action by two researchers. Furthermore the same act can have different meanings at different times. Ayres and Poirier (1996 p166) state in this regard that "since each researcher is unique, and brings to analysis a unique aesthetic response, it is not surprising that multiple interpretations can emerge from different researchers' encounters with the same artistic text". This variation in interpretation between researchers relates to their theoretical and historical backgrounds.

Through its aim of searching for meaning within lived experience, hermeneutic phenomenology therefore connects well with the research question. It afforded me a chance to involve myself in "the attentive practice of thoughtfulness" (Van Manen, 1990 p12). Through immersing myself in the women's experiences of childbirth, I was able gradually to express my interpretation of those experiences. Heidegger's goal is to understand the lived experience; this understanding involves the concept of the hermeneutic circle. This device has enabled researchers to gain a deeper understanding by relating each new interpretation to past experience based on historicity of understanding.

### ***3.6.1 The Hermeneutic Circle***

This expression refers to the way people develop understandings of themselves and their world. It is a metaphor for the analytical movement between the whole and the part, in which each gives the other meaning (Heidegger 1962). The interpreter needs some pre-understanding in order to understand the text and the resulting enhanced understanding consequently illuminates the starting point (Gadamer 1989). Crotty (1996 p92) defines the hermeneutic circle in another way: its purpose is "to understand the whole through grasping its part, and comprehend the meaning of parts through divining the whole". This circularity of movement defies termination: it is fundamental to our relationship with the world that we are

always understanding and interpreting it. The processes of clarification, interpretation and understanding have no beginning and no end.

Heidegger (1927/1962) and Gadamer (1975) both use the hermeneutic circle. The former claims that we are an integral part of an external reality and consequently we are in the position of Being-in-the-world. He asserts that by leaping into the circle of understanding we can ensure “that we have a full view of Dasein’s circle of being” (Heidegger 1962 p 363). To achieve understanding of the experience we must continuously pass between the part and the whole of the experience until we gain the depth of understanding of the text. According to Heidegger, pre-understanding is the structure of being in the world. Heidegger talks about “historicity of understanding” (Heidegger 1962), arguing that we can understand our world by the experiences of our lives, and that through this we develop our own world. This is the essence of Heidegger’s hermeneutic circle. Heidegger stresses that an individual’s interpretation of a phenomena is based on their historical background, a background (or alternatively a set of pre-understandings, prejudices, preconceptions, and presuppositions constantly determines our standing, so that the individual cannot step outside of or put aside their pre-understanding of the world. Any researcher using Heideggerian hermeneutic phenomenology must be aware of pre-understanding, because in the interpretative process the researcher cannot be free of this historical background. Heidegger goes so far as to contend that nothing can be encountered without reviewing the individual’s pre-understanding. He describes the relationship between the human and the world as indissoluble. Munhall likewise argues that we were constructed by the world and meaning is found through that construction, whereas we construct this world through our background and experiences (Munhall 1994).

Gadamer (1989) maintains that we can understand the whole from the individual and the individual from the whole. He highlights three concepts implicit in the hermeneutic circle: prejudice, play and the fusion of horizons. Horizons comprise pre-understandings or prejudices that enable us to make sense of events and people.

Gadamer develops Heidegger’s proposal by adding that being can be articulated by language, understanding can be achieved by language, and that in the hermeneutic circle understanding is inextricably connected with interpretation and application (Rapport and Wainwright 2006). Gadamer (1989) finds that hermeneutics is not a process of understanding, and clarifies the conditions in which understanding takes place thus: “Hermeneutics must start from the position that a person seeking to understand something has a bond to the subject matter that

comes into language through the traditional text and has, or acquires, a connection with the tradition from which it speaks” (Gadamer 1989 p295). He stated that “language is the universal medium in which understanding occurs...understanding occurs in interpretation” (Gadamer 1989 p389). He sees interpretation as a fusing of horizons, a circular process in which the anticipation of the interpreter reacts with the meaning of the world experience.

According to Gadamer (1989) the individual’s lack of horizon means that they cannot see far enough to perceive the meanings behind the text. Having a new horizon is therefore an essential aspect of the interpretive process. He asserts that individuals must not be rigidly attached to their pre-understandings but must remain able to accept the text’s meanings. In other words, the individual will be able to recognise the uniqueness of meanings held by others. Through this, Gadamer (1989) acknowledges that bracketing is impossible in the understanding process, and he supports the idea that prejudice plays a positive role in the search for meaning. Benner (1994 p 19) added that “when we are able to understand the situation of other people, it is not because we are able to look deeply into their souls but because we are able to imagine their life world”.

The hermeneutic circle allowed me to interpret the participants’ words in a different way. I built my pre-knowledge into all the new meanings arising during the interviews, and through my subsequent contact with the women, and I thereby gained further insight into their lived experiences. I believe that my background was a part of me throughout my research, and I consider my pre-knowledge to be the starting point of the study. Through my involvement with Arabic Muslim women, aspects of my pre-knowledge came constantly to mind and caused me to reflect on the transcript data, which in turn allowed me a far deeper insight into women’s experience. This is supported by Heidegger’s proposition that it is the shared social practices of the group that underpin the social meaning of a new experience (Heidegger 1927/1962). This was given effect in this study, in which I had the same social context as the women, and it helped me identify the meanings behind the words that might have been missed by someone from a different social context.

Gadamer’s (1989) notion of researchers bringing their own horizons or prejudices to a study, as well as the belief that this pre-knowledge has enabled me to interpret data and formulate understandings, has guided my study. On the other hand my own horizons have challenged me in another way during the research process: it was difficult to become detached from my

context as an Arab Muslim woman and to focus on the women's worlds as a person from a different social context. It was extremely difficult to bridge the gap between these two perspectives. When I commenced interviewing, I regarded some aspects of the women's experiences as normal in Arabic Muslim culture while for my research supervisory team these were more of an issue. As mechanism for ensuring the full exploration of all relevant issues in such experiences, each interview was reviewed by my research supervisors and detailed comments made for guidance in further exploration of some relevant issues. This process enabled unique insights into the research topic, as two different views were addressed during data collection: the views of Arab Muslim women as represented by the researcher, and the views of people from different social backgrounds as represented by the researcher's supervisory team. In order to achieve rigour in this study, it was then important to combine these two perspectives in order to interpret all the meanings in this experience. I also documented my own thoughts of what it was like to be a migrant Arab Muslim woman giving birth in a foreign country, and I wrote memos giving my impressions after each interview. I was aware during the analysis process of the necessity of not applying my interpretation only, but to enable the women's own expressions of their experiences to be heard. This will be explained more in the research design chapter.

At the most basic level, this Heideggerian hermeneutic study will encourage discernment and sympathy by raising midwives' awareness of "what it feels like to be in a given situation" (Kearney, 2001, p 150).

My role as facilitator was to obtain a full description of the women's experiences and to ask for more clarification; it was not to impose my own interpretations or perspectives.

### ***3.6.2 Studies Utilizing Hermeneutic Phenomenology***

Many researchers have used Heideggerian hermeneutics to investigate and define the experiences of those in their care. A brief overview will be given of some studies using this form of phenomenology.

Rapport (2003) in her doctoral thesis used Van Manen's interpretative phenomenological method to explore the beliefs and experiences of potential egg sharing donors undergoing

fertility treatment. The study was conducted in order to gain a deeper understanding of the decisions made by sharing donors, and to prepare health care practitioners to deal better with patients' needs, desires and experiences. Rapport was guided in her analysis by van Manen's framework (Manen 1991). Six themes emerged from the analysis: egg sharing as a context, doubt, coping, exchange, empathy and motherhood.

Evans and Hallett's (2007) research was into 'living and dying: a hermeneutic phenomenological study of the work of hospice nurses'. They affirmed that hermeneutic phenomenology is an important method for uncovering the complex realities of nursing work. In this study they focused on the meaning of nursing care for dying patients, from both nurses' and patients' perspectives. Three themes were identified as characteristic of the nurse's experience: comfort and relief, peace and ease, and spirituality and meaning. They offered insights for nurses in both hospice and other settings and they gave a number of perspectives on the nature of 'comfort care' and the meanings attached to it by interpreting the unique perspective of hospice nurses.

A midwifery study conducted by Shepherd (2005) was based on the experiences of women suffering from Symphysis Pubis Dysfunction (SPD) during pregnancy and three months after birth. She used Heideggerian phenomenology to understand the women's' experiences. Colaizzi's (1978) framework was used to analyse the data. The findings were presented under four headings: pain, lifestyle adaptation, emotions, and health professional's support and information.

Gestational Diabetes: The Meaning of an At-risk Pregnancy was a study conducted by Evans and O'Brien (2005). The authors used a hermeneutic phenomenological approach to gain an in-depth understanding of gestational diabetes as pregnant women meaningfully experience it. The findings challenged health care professionals to reassess and openly discuss their present models of care for pregnant women and their families.

### ***3.6.3 Critiques of Hermeneutic Phenomenology***

Critiques of research grounded in Heideggerian philosophy centre on the objection that such research has not been well developed, because this philosophy holds that knowledge is never

independent of interpretation. Therefore the findings are not considered to be true or valid (Rolfe 2006). Evaluation of Heideggerian studies can be achieved by a convergence during data interpretation of participants' and researchers' perspectives. The perspective of the participants was the focus of greater part of reports; some researchers "let the data speak for itself", thereby ignoring the self-reflection regarding personal experiences that played a role in their interpretations (Draucker 1999 p362). In this study I have tried to establish trustworthiness by returning the transcribed interviews to all the women and by providing them with the final report for their perusal if they wished. I sought their approval so that my interpretations would reflect their view. To achieve credibility, direct quotes from the text and the transcribed data were also used to illustrate the themes that reflected the women's experiences.

The studies using Heideggerian phenomenological methodology mostly identified methods and approaches, but the research processes rarely discussed the instances when the interpretations of the researcher and participants were at variance. Draucker (1999) argues that these differences are unavoidable and should be reflected in the findings. In this study at some points my interpretation was different from the women's interpretation. For example, the women asserted that there was fairness of care for all consumers of maternity services in the UK, because maternity care was free for all childbearing women, so they perceived the standard of care the same for all on this premise. However I noticed when talking and analyzing transcripts that, whilst care is free and therefore equitable, the care itself is not due to language barriers and cultural dissonance between women and their care providers.

Whitehead (2004) observed that the hermeneutic phenomenological approach is time-consuming because of data collection and in-depth analysis, and that it demands an emotional investment because of the personal depth and richness of the data shared. Researchers and participants must be prepared for the emotional and time investment necessary to collaborate in this research approach.

Some have criticised the interpretative approach as being biased toward the researcher's pre-understanding rather than remaining focused on the participant's lived experience; in this regard, Heidegger warns that "Whenever a phenomenological concept is drawn from a primordial source, there is a possibility that it may degenerate if communicated in the form of an assertion. It gets understood in an empty way and is passed on, losing its indigenous character and becoming a free-floating thesis" (Heidegger 1962 p62). Consequently, during



the interviews I tried to clear my mind and let the women talk freely about their experiences, sometimes guiding them indirectly to explore some relevant issues. I acknowledge that the women's descriptions and interpretations of their experiences differed from mine. It is characteristic of hermeneutic phenomenology that varied interpretations will arise.

Whitehead (2004) criticises hermeneutic phenomenology because the themes emerging from the text will be different for each reader, as readers themselves are interpreters, and may not share the researcher's interpretation. Also, each individual interpretation will change over the time as their horizon progresses. As a researcher who used this approach I see it as enriching our understanding of the experience, as the diversity of interpretations will cover all possible perspectives. It is a given that each person has a unique background, and any interpretive work will depend on the individual's historical background; it is therefore taken for granted that interpretations will differ according to the variety of readers. In this study the aim was to interpret the meaning of the experience from the perspective of migrant Arab Muslim women. I wanted to reveal what these experiences mean for an Arab Muslim woman, and how these experiences differ in significance for other people from different backgrounds. This was achieved by interpreting those experiences from the viewpoint of a researcher who was also an Arab Muslim woman who had migrated to the UK.

### **3.7 The Impetus for the Study**

I acknowledge that my personal experience has influenced my decision to research the experience of childbirth of migrant Arab Muslim women in the UK. Additionally, I acknowledge that my experience has also affected the way I chose to research this topic.

I was working as a midwife in an Arabic country not my own. I was in charge of the antenatal clinic and dealt with women of various nationalities. In my work experience I recognised the challenges that migrant women faced during childbirth in a foreign country. With respect to this extraordinary period in her life, any woman during her childbirth needs more care and support than usual. Physiologically she will be more sensitive because of the effect of hormonal changes, and migration only makes the situation worse.

I am a woman who has delivered all her children as a migrant, and who has experienced some of the possible difficulties that may face such women. However, I was not isolated by

language and culture, as I gave birth in another Arabic country. Migrant Arab Muslim women experiencing childbirth in the UK live in a country where the language and culture are alien to them, making their situation even more challenging than my own.

Childbirth is generally a challenge to all migrant women in the UK, especially for Arab Muslim women (Pollock 2005). In Arabic society, the woman during childbirth is the centre of attention for all the other women in her family, while as a migrant she loses this advantage, while also being subjected to more pressure as she has to exist in different culture. She may therefore rely more heavily on her husband, who in turn may be unprepared for this, perceiving that childbirth is a female issue.

During my work in a foreign Arabic country I tried as much as I could to soothe the women and discuss the challenges they faced with them in detail. When I received a scholarship to do a PhD in midwifery, I decided that my research topic would be the experience of migrant women during childbirth. After my arrival in the UK, I heard about and experienced for myself the prejudice and discrimination against Arab Muslims, particularly after 9/11 and the July 2005 London Tube bombings. This motivated me to focus on the experience of Arab Muslim women, a decision only made easier by the fact that I am a member of this group.

From personal interest, I started to search the literature for information on the childbirth experiences of migrant women. Two particular issues motivated me to investigate the topic in more depth. The first was that migrants' pregnancy outcomes are known to be significantly poorer compared to those of the native population (Macfarlane 2000). The second was that the Healthcare Commission's 2005 review of North West London Hospitals NHS Trust indicated that nine of the ten women who died in childbirth were from a minority ethnic group (Healthcare Commission 2007).

In this study some problems were found to be common to all migrant women in the UK. I cannot attempt to generalise these findings to all women, but the study may give an overview of the challenges midwives might face in caring for migrant Arab women, help them to provide sensitive and appropriate care. Moreover, I anticipated that my research could have great practical implications in improving maternity services for Arab Muslim women in particular and migrant women in general.

### ***3.7.1 Personal Reflection on My Own Childbirth Experiences***

In Heideggerian phenomenology the researcher is in-the-world, and is essentially a part of the research process. It was important to establish a rapport between me and the world of the interviewee. This obliged me to document some of my childbirth experiences as a migrant Arab Muslim woman in one Arabic country, to show how my interpretation was developed.

Nine years ago I married and moved with my husband from Jordan to another Arabic country in the Gulf region to work there. I bore two children in the first two years of my marriage, after which I waited four years until my planned third pregnancy.

It was a very difficult experience; I had just married and moved to another country far away from my family. I was struggling to manage with my children alone. It was very hard to deliver alone, without support from my extended family. My husband could never take the place of my mother; he was unable to support me enough, not because he did not want to but because he did not know how. This made me realise that the Arab Muslim man cannot replace the woman in her traditional role within the family. In Arabic culture men are not responsible for cooking or cleaning in the house, so in circumstances like this they find adopting these roles challenging. This situation created many difficulties for me. I remember that I was discharged from hospital on the second day after delivering, and went home to take full responsibility for the household. For example, I cooked the meals and bathed my children without resting long enough after giving birth. Even now the memory of this time pains me, and I ask why I put myself through this. When I have attended deliveries in my own country and have seen how the women there are pampered during childbirth, I know how hard it was for me compared with their experiences.

I had some friends and neighbours in the country to which I migrated, who helped me during my pregnancies. I had severe hyperemesis, and they constantly sent me food because they knew that I could not cook. They also offered to help with all the household chores, but I refused: my attitude is that I do not like to be helped by non family members. At that time I received little assistance from my husband, but I considered this as normal because in Arabic culture husbands do not help their wives.

In coming to the UK I found differences between my experience as a migrant giving birth and those of the women I interviewed. It could be that the effect of the prevailing culture in

the UK changed the role of the husband. Here it appears to be more acceptable for men to take on household duties.

Prior to the commencement of the study I anticipated that the possible difficulties confronting women would be communication problems with midwives and the lack of social support. During the data collection, however, many relevant issues started to emerge from the women's interviews; these were different from my experiences and went well beyond the issues that I had expected to discover. These differences will be explained in more detail in the interpretation process.

### **3.8 Conclusion**

This chapter has shown the relevance of the phenomenological approach in studying the meaning of human experience. In addition, the two types of phenomenology were discussed, as was the process by which Heidegger built his work on that of Husserl. It was also shown that ontological-hermeneutical phenomenology was the most appropriate approach with which to reveal the meaning migrant Arabic Muslim women ascribe to their childbirth experience in the UK.

I also briefly presented some researches that use a phenomenological approach. Finally, criticisms of hermeneutic phenomenology were considered.

In the next chapter how the project was designed and conducted, based upon the methodological principles explored in this chapter, will be discussed.

## **CHAPTER FOUR**

### **RESEARCH DESIGN**

#### **4.1 Introduction**

This Heideggerian hermeneutic study investigated the experience of migrant Arab Muslim women during the period surrounding their childbirth in the UK. In the previous chapter I discussed the reasons for choosing Heideggerian hermeneutic phenomenology as a philosophical basis from which to address my research question “What does it mean to be a migrant Arab Muslim woman experiencing childbirth in the UK?”

This chapter describes the study’s design in detail, as well as the implications of Heideggers’ hermeneutics for the way the data was collected, analysed and interpreted. As previously noted, the choice of research methods was dictated by prior methodological decisions. The method of data collection will be discussed. This will be followed by a discussion of the way respondents were sampled and accessed. Consideration will be given to the ethical issues that were considered in the design and conduct of the study. The chapter then discusses the process of data analysis and closes with a consideration of the steps taking to achieve rigor.

#### **4.2 Study Aims**

The overall aims of this study were to gain ontological insight into the experience of migrant Arab Muslim women during their experience of childbirth in the UK, and to provide a descriptive interpretive account of their lived experience.

In keeping with the principles of Heideggerian hermeneutic phenomenology, the focus of the inquiry was adapted so as to reveal the meaning of being an Arab Muslim woman who has utilised the maternity services in the UK during her childbirth. The research aims were:

- To explore migrant Arab Muslim women's experiences of maternity services in the UK.

- To examine the traditional childbearing beliefs and practices in Arabic Muslim society.
- To suggest ways to provide culturally sensitive care for this group of women.

### **4.3 Research Strategy**

The particular feature of the study was the detailed interviewing of a small number of women through their period of childbirth from late pregnancy until three months after delivery. The needs and experiences of Arab Muslim migrant women before, during and after childbirth were explored by conducting a series of in-depth interviews with eight women. Each interview was conducted in either Arabic or English according to the interviewee's preference. Each woman was interviewed three times; during the third trimester of pregnancy (after 28 weeks of pregnancy), one to two weeks after the birth of their baby and one to three months later. The first interview was focused on the experiences of pregnancy, the second on those of birth and the third on postnatal experiences, all of which allows the exploration of all aspects of care during childbirth. This produces a sense of continuity within the particular cases. Moreover, there is evidence that more accurate views resulted from interviews conducted while the women were still in the particular stage of their childbirth experience, and their memories of events and conditions were still fresh (McCourt & Pearce 2000). The longitudinal nature of the study, in which women were interviewed three times, allows the collection of data in depth. It also permits the researcher to explore new issues emerging from the data, and permits the participants to explain issues they do not recall, or even that they have decided to withhold in previous interviews (Whitehead 2004).

### **4.4 Ethical Issues**

The qualitative paradigm requires particular ethical consideration by researchers, with the emphasis on the aim on depiction and understanding. Consequently, it is fundamental that midwifery researchers take into account the possible ethical dilemmas that may emerge during their qualitative research. Since the Declaration of Helsinki in 1964 it has been an essential requirement for all healthcare researchers to be aware of potential ethical problems in qualitative research (Rogers 2008). The nature of this study means that migrant Arab Muslim women were the objects of inquiry. This desired sensitivity from me as a researcher

to prevent them being detrimentally affected by the conduct of the study. Also consideration needs to be given to ensuring researcher safety during data collection periods.

The British Psychological Society has produced a set of guidelines, "Ethical Principles for Research with Human Subjects", used in this study to ensure that appropriate ethical principles have been followed (British Psychological Society, 2006). It is very important that strict ethical standards are maintained at all times (Bell 2005; Polit and Beck 2004).

The researcher must have the foresight to obtain ethical approval from the local research ethics committee before the commencement any study involving human participants. The aim of such committees is "to safeguard the rights of research participants and will ensure that researchers are competent and trustworthy and therefore able to guarantee that basic research tenets will be adhered to" (Rogers 2008 p179). Through the study, I was fully conscious of these requirements. I sought and gained ethical approval from De Montfort University's Research Ethics Committee (see Appendix 1).

Data collection commenced after obtaining this approval. Once the women had volunteered to take part in the study, I sent them an information sheet about it and asked them to sign a written consent form. The following points were emphasised prior to each interview:

- Participants have the right to choose not to participate.
- Participants may terminate their participation at any point without repercussions.
- Participants should be encouraged to ask for explanations at any time.

Phenomenological enquiry is often personal and intimate, and the maintenance of privacy is therefore paramount (Morse and Field, 1996). It is important to guarantee that all data was maintained securely and pseudonyms were used throughout to protect identity. All research documents were kept in a locked drawer in the study room in my house, and only I had access to this information. Audiotapes of in-depth interviews were stored on a compact disk and also on computer. Computerised information was password-protected and other copies of CD were stored in a number of secure places. CD will be destroyed after completion of the PhD. Transcripts will be kept on a password-protected computer for a period of five years to facilitate ongoing publication of study findings.

The women were not worried about anonymity. However, I explained the need of understanding the ethical principles set out by the British Psychological Society.

As a data collection method, the interview might trigger hidden feelings of distress attributed to their experience of childbirth. If any women exhibited any signs of emotional distress during an interview, I would stop and debrief her, providing her with details of counselling, self-help and healthcare services she may wish to access to obtain support. All the women were happy to participate; four women exhibited some degree of discomfort and were upset, for a short time only. Insofar as their recollections of their experiences were unpleasant, they showed a certain amount of anguish. When I observed their distress, I immediately gave them the opportunity to stop the interview and debriefed them, but all chose to continue the interview after a short break; they did not require counselling.

For my own safety, my supervisor was informed when and where an interview was to take place and I agreed with her that I would contact her when the interview was complete. It was arranged that, if I did not contact her within a specified time, she would contact the police.

The other ethical dilemma confronting me was regarding the one woman who was not interested in continuing with the study following the antenatal interview. I understood that and did not ask her for any clarification. Moreover, I kept in contact with her, visited her after her delivery and attended the Aqiqa she performed for the baby. I thanked her for the information she gave in her antenatal interview, and she had no objection to this being included in the study.

On the whole, I enjoyed the interviews with the women. I appreciated the time they devoted to describing their experiences of childbirth. I also sensed that they enjoyed talking to a genuinely interested listener. Directly after the completion of the postnatal interviews I sent each woman a handwritten card thanking her for participating in the study. I kept in touch with the women and met them often after the interviews were over; I was grateful to them for their willingness to share their experiences with me.



## 4.5 Sampling

Sampling refers to the process of selecting participants from a given population for the purposes of research (Silverman 2006). In qualitative research, the type of sampling is determined by the methodology used to investigate the topic.

The dominant sampling strategies in qualitative research are non-probability and purposive sampling, both of which look for information-rich cases that can be studied in depth. Purposive sampling also selects participants within specific categories such as age, culture and experience; it is not purely random. Silverman (2006) argues that purposive sampling needs critical thinking about the population parameters that the researcher is interested in, and that sample cases are chosen carefully on this basis. Ploeg (1999) argues that the decision to use purposive sampling also influences the locations in which data is collected, as well as its constituent incidents and phenomena and practise of data collection. She adds that sampling in qualitative research is flexible, evolving as the study progresses and continuing until a point of redundancy is reached, with no new themes emerging from the data and the amassing of a sufficient amount of information in depth to meet the purposes of the study. This stage, called data or information redundancy, is comparable to data saturation - i.e. no new relevant data seems to emerge, the information being seen to be repeating itself (Meyrick 2006). It may therefore be impossible to specify the number of participants required at the commencement of the study (Crouch and McKenzie 2006).

Purposive sampling was chosen as the sampling strategy for this study. It is well suited to phenomenology, as it permits the selection of interviewees whose qualities or experiences permit an understanding of the phenomenon under investigation and are therefore valuable (Polit and Beck 2006).

The nature of this study, which intends to provide a dense description of the women's experiences, did not require a large number of participants. Conducting the study with eight women was therefore sufficient. The small number of participants does not mean that the data obtained lacks credibility. On the contrary, "a small number of cases will facilitate the researcher's close association with the respondents, and enhance the validity of fine-grained, in-depth inquiry in naturalistic settings (Crouch and McKenzie 2006 p.483). However, it must be acknowledge that a small sample size cannot therefore be generalized.

The aim of Heideggerian hermeneutic study is to create a rich description of the phenomenon and interpret the meaning hidden in the experience. I included only those informants with a rich experience in the phenomenon under study. The population targeted in this study was Arab Muslim women living in the Midlands region of the UK. Inclusion criteria were:

- Pregnant women living in the East Midlands
- Women over the age of 18
- Migrants to the UK in the past 10 years from the Arab countries of
  - Algeria
  - Bahrain
  - the Comoros Islands
  - Djibouti
  - Egypt
  - Iraq
  - Jordan
  - Kuwait
  - Lebanon
  - Libya
  - Morocco
  - Mauritania
  - Oman
  - Palestine
  - Qatar
  - Saudi Arabia
  - Sudan
  - Syria
  - Tunisia
  - the United Arab Emirates
  - Yemen
- Women receiving maternity care in the UK during pregnancy, labour and the postnatal period

I chose women living in one geographical area for convenient access. The women had to be aged over 18 because this ensured that they were mature enough to articulate the meaning of their experiences and that they had the ability to compare their experiences with their equivalents in their own countries; this could not be achieved with migrant women younger than 18, who may have been too immature to grasp the meaning of this research. It was also important that participants had experienced maternity care in the UK for the period covering late pregnancy until three months after delivery in order to obtain a full and continuous description of the experience. The other inclusion criteria was that prospective participants must have migrated to the UK less than ten years prior to the commencement of the study, as any longer period would see her well settled in to life here; she would have overcome more of the challenges involved, and her adherence to Arabic culture may be less than that of more recent migrants.

## **4.6 My Role as Researcher in the Research Process**

In the context of this study I considered myself to be part of the women's world who participated in this study. To illustrate this I will firstly discuss the role I played in this study, including the experiences that led me to consider myself an insider, and that reveal how this role influenced my choice of research topic, the purpose of my study, access to participants, the collection, analysis and interpretation of data, and the maintenance of the study's rigour.

I played several roles (interpersonal, emotional and cognitive) during data collection, seeking to understand and interpret what was said and what remained unspoken. Through my own personal experience of being an emigrant and of giving birth while in that status, I know what it means to be migrant woman giving birth in different country than your own. Moreover, my experience of childbirth influenced my choice of research topic, as I have already mentioned. Being a migrant Arab Muslim woman conducting research into those like me who have experienced childbirth in the UK made me an "insider" researcher and gave me significant benefits. Kanuha (2000) maintains that "for each of the ways that being an insider researcher enhances the depth and breadth of understanding to a population that may not be accessible to a non-native scientist, questioning about objectivity, reflexivity, and authenticity of a research project are raised" (p 444).

My access to Arab Muslim women's society was made significantly easier by my being in this position. I met the head of the Islamic Centre, who arranged for me to give some presentations each Wednesday where the women came to study the Qur'an. I also started attending these classes. My own identity as a migrant Arab Muslim woman facilitated my access to potential participants, particularly in mosque/community groups. In this respect, Hodkinson (2005) notes that differences in ethnicity between researcher and participants can inhibit rapport between them. While specific identity criteria may affect interviews, he argued that the insider's perception has a positive effect on the quality of interpretation and understanding. In this study, rather than being dismayed by an approach from someone of an alien culture, the women expressed a sense of relief that I was an Arab Muslim woman who understood their own background. During the interview they freely discussed many cultural issues because they knew that I understood why they behaved in this way. For example, one woman discussed the male-dominated hierarchical society in Arab countries not in terms of gender inequality but as a cultural issue, in which light it is also considered in this research.

Breen proposes three merits of being an insider (i.e. belonging to the group under study): the possession of a superior understanding of the group's culture; the ability to interact naturally with the group and its members; and an established, and therefore greater, relational intimacy with the group (Breen 2007 p163). Hodkinson (2005) adds that holding some measure of insider status can positively affect interaction with participants, that there will be a general willingness to participate in the study, and that trust and cooperation will be extended to the researcher.

Hewitt-Taylor (2002) states that insider research serves to enable a depth of information that might not be obtainable otherwise, because the outsider would not be offered as wide a range of information. In my study, I felt that my position as an insider gave me a comprehensive understanding of the many issues pertaining to the women's experiences. They freely discussed some intimate aspects of those experiences with me that may have posed difficulties for a researcher of a different ethnicity.

There were of course also significant problems that, if due caution was not exercised, would have affected the quality of the interviews. I have already dealt with some of these. Hodkinson (2005) advises the insider to employ a careful and reflexive approach to avoid such difficulties as may arise during the study.

My position as an insider allowed me an initial degree of familiarity that actually presented me with some difficulties in collecting data during the interviews. The women assumed that I already knew the answers to some of the questions I posed, as I shared the same social context with them. When I probed for more information, the women knew that I already knew the answer, and this appeared to annoy them. Kanuha (2000) noted that she did not realise that her relative intimacy with her respondents was a potential difficulty until she read the interview transcripts, and she recognised how much of the interaction between her and her interviewees had gone unspoken. To overcome this difficulty during data collection, I asked my interviewees to try to forget that I was an Arab Muslim woman and to treat me as if I had no idea of Arab culture or of Islam. This strategy produced invaluable and sometimes surprising data.

On the other hand it was difficult to determine how I could view the women's status objectively, as I was already a member of their group. Sometimes the women discussed issues of importance to midwives in the UK, but I subsequently realised how difficult it was during the interviews to expand on these discussions, because I assumed that I knew the women's views on these issues, and that I consequently understood why certain decisions had been made. After my supervisors reviewed the transcripts, I became aware of how much relevant data had gone without comprehensive exploration. In an attempt to overcome this problem I allowed the women to discuss their experiences in depth, to clarify statements and to seek more detail. My role as an interviewer fluctuated between activeness and passivity. Sometimes I used an active listening technique, I gestured with my head to encourage them to continue or to elaborate, and used "fillers" such as "oh-haaa" for the same purpose. As the women perceived that I really was listening to them, they became more voluble. I did not allow anything ambiguous to pass without asking for clarification, using such phrases as "Sorry, I don't understand you, can you explain it more for me?". Sometimes it was difficult for me to interrupt the flow of the discussion, in which case I waited until the end to ask for more clarification about important aspects arising from their answers.

Herwitt-Taylor (2002) asserts that any kind of research is subject to bias. I was aware that I started the study with my personal pre-understanding. I recorded my personal experience of childbirth as a migrant women and my own perception of my position. This helped me during the collection, analysis and interpretation of the data. I also acknowledged that I shared the

same social context as the women, and that I might consequently miss some important aspects of their experiences. Instead of focusing on what I thought was important, I therefore documented all the issues that emerged. To the same end I also tape recorded all the interviews. Rigour was ensured by reflecting the voice of the women in the experience, not by my personal assumptions about women's experience. Herwitt-Taylor (2002) suggests supervision by someone outside the study situation as a way of minimising the risk of any such bias. My supervisory team always reviewed the data and my interpretations, and offered critical comments on the study findings.

## **4.7 Access to participants**

I gained access to Arab Muslim migrant women in the communities in which they lived. I targeted them through religious institutions and community centres. I contacted local mosques and community groups and requested them to give women's groups information about my study, see Appendix (2) for presentation guide. At presentations, all women were given an information sheet with a request to contact the researcher by phone after one week if they were interested in taking part in the study; five women contacted me personally to participate in the study. In addition, a request was made to place a notice in each mosque/community group area inviting women to participate in the study and asking them to contact the researcher by phone or email for further information see Appendices (3 and 4). Three women were recruited to the study in this way. The women who learned of or participated in the study told other pregnant women and directed them to contact me directly (this is known as snowball sampling). Seven women approached me via this snowballing technique, and I forwarded them information about the study. I then contacted the participants by phone and answered any questions and, if they wished to participate, arranged for the first interview to take place. In total I approached fifteen women, only ten of whom fitted the study's inclusion criteria.

I also attended a number of social and religious events for Arab Muslim groups. I tried to build a rapport with all the women participating in the study. I shared the Aqqa<sup>1</sup> ceremony with five women, during which they introduced me to other Arab Muslim women who were

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<sup>1</sup> Aqqa: "the celebratory sacrifice of a sheep on the birth of a child. The meat is distributed between family members and the poor (Sheikh&Gatrad 2000 p133).

pregnant. I also participated in Al-Eid prayers and I went with my family to the dinner in a mosque where the Arab Muslim families gathered. By this means I was introduced to a large number of Arab Muslim women in the area. One of the women participating in the study went to hospital for a scan, and while she was there she saw another Arab woman, told her about the study and phoned me. In addition I met the head teacher of an Arabic school who introduced me to those mothers of the students who were pregnant. .

Ten women participated in the study. Two women dropped out after the first interview. One had migrated to the UK in 1993 and the themes which emerged from her interview were totally different from the others because she displayed a high level of acculturation to British society, all her previous deliveries having been in England. The second participant revealed at the first interview that she planned to go to her home country for the birth of her baby.

## **4.8 Data Collection Tools in An Hermeneutic Inquiry**

Everyday practical activity is the primary source of knowledge in hermeneutic inquiry (Wojnar and Swanson 2007). Human behaviour becomes analogous with the interview text that is presented and interpreted in order to reveal the concealed meaning. The data from the text analogous can come from interviews, participant observation, diaries and samples of human behaviour. There is an overemphasis on the use of interviews and focus groups as data collection methods in hermeneutic phenomenology, and a comparative neglect of observational or other methods more concerned with activities than perceptions (Britten 2005). The purpose of the interview is “to find out what is in and on a person’s mind..., to access the perspective of the person being interviewed..., to find out from them things that we cannot directly observe” (Arksey and Knight 1999 p32). Hermeneutic phenomenology as discussed earlier focuses on the meaning and interpretation of people’s experiences.

Interviews can be conducted communally (DiCicco-Bloom and Crabtree 2006), in which case they take the form of focus groups conducted with several participants sharing their own knowledge or experiences about specific issues. The in-group interview (focus group) was rejected as a method of data collection for this study because of its public nature, which may prevent the deep exploration of personal experiences by individual participants. In addition,

Arab women may find it difficult to talk about such issues in a group setting because of cultural inhibitions toward the discussion of personal matters in public situations.

Individual in-depth interviews are widely used by healthcare researchers to explore the interviewee's view of events and experiences related to health and the delivery of healthcare. The individual in-depth interview was chosen as the method of data collection for this study because it allows women to speak freely, as well as allowing the researcher to deeply explore any social and personal issues. In such a relaxed environment, interviewees can present their personal experiences honestly and feel totally at ease in doing so. The aim of the individual in-depth interview in the present study was to gather a wide range of varied data, and to allow the women to describe their worlds in their own words so that they could emphasise what they consider to be important, and also so that the researcher can explore any relevant issues (DiCicco-Bloom and Crabtree 2006).

The course of data collection was shaped by the aim of this study: the meaning behind childbirth as experienced by Arab Muslim women who had migrated to the UK. In order to reveal this meaning, I encouraged the women to talk freely about these experiences. Having chosen interviews as a data collection tool, a decision needed to be made about the type of interview that would be used. Interviews that adhere to hermeneutic phenomenology framework are loosely differentiated as unstructured or semi-structured.

The unstructured interview originates from the ethnographic tradition of anthropology (DiCicco-Bloom and Crabtree 2006). This type of interview is non-directed, no restriction being placed on the questions asked, and it is flexible and more informal than the semi-structured interview. No guide is used, and participants are allowed to speak openly, frankly and give as much detail as possible. The interviewer asks questions of the participants in order to encourage them to express their opinions and to share their knowledge and experience. It needs expert interviewers, requires good communication skills, and also demands that interviewers must be good listeners and be thoroughly familiar with the context of the relevant data given by the respondent. Moreover, the interviewer must know how to direct the interview so as to obtain the relevant data, because the respondents may become sidetracked onto insignificant issues. Ultimately, it may cause difficulties in coding and analysing data. Unstructured interviewing is a very flexible approach, but it was not chosen



for this study because it was anticipated that respondents would focus on the area of study, and I was not an experienced enough interviewer to direct them properly in this event.

#### ***4.8.1 Semi-Structured Interviews***

The semi-structured interview is the most widely used interviewing format in qualitative research (Sorrell and Redmond 1995). Broad questions are asked in conversation, with new questions prompted by the resulting discussion. The researcher has a list of key themes, issues and questions that must be covered. To this end, sets of open-ended questions were prepared, allowing the participants to express opinions during discussion, facilitating a relatively unrestricted, relaxed discussion based around a fixed topic (Ploeg 1999). The majority of questions will be discussed during the interview. Interview questions are generally expressed in simple terms, without technical jargon or expressions, and start with more general questions or topics (DiCicco-Bloom and Crabtree 2006).

The data collection tool chosen for this study was the semi-structured interview. This form allowed the interviewer to direct the participant towards a discussion of issues of relevance to the study, while at the same time allowing them to emphasise issues they perceive as important to their experience (Corbetta 2003). This method was also chosen because it is keeping with the hermeneutic phenomenological approach. More questions are predetermined than with the unstructured interview, though they are sufficiently flexible to allow the interviewee an opportunity to shape the flow of information (Bicicco-Bloom and Crabtree 2006).

Prior to the first interview each women received a copy of the information sheet in both Arabic and English (see Appendix 5&6). This was supported by verbal information explaining the study and what it entailed for participants. The information sheet included a full description of the study, what was required from them and what the benefit for them might be. It stressed that participation was voluntary and gave contact details for me, my first supervisor and the research office in the university, for any inquiries they might have. They were assured of confidentiality, and also that their participation would not affect their future treatment.

The first time I interviewed each one, I asked her to sign a written consent form (see Appendix 7&8). At the start of each interview I reminded the women, as a migrant Arab Muslim woman myself, that I was not there to judge their lifestyles or their husbands. I explained that the objective was for them to describe their own perspectives of what happened to them during the period of childbirth, and I assured them that there would be no repercussions on my future association with them following what was said in the interview. Wengraf (2001) states that the interviewer should be non-directive, non-judgmental and encouraging, which reflects the aim of allowing the women to talk about their experiences as they view them. The interviewee must also feel assured that they can communicate whatever they want to without being judged (Wengraf 2001). On the other hand, I gave the woman the opportunity to withdraw at any time prior to and during the study, even after initial consent was given.

I created an interview guide to help guarantee that key areas of the interviewee's experience would be covered, after comprehensive reading of the academic literature on the topic (see appendices 9, 10, 11). Before commencing each interview, I read the interview guide several times to remind myself of all the relevant points that should be discussed in depth during the interview.

The interview questions did not follow the same sequence for each participant, as their answers could prompt fresh questions. Nor did I meticulously follow the interview guide. When participants started discussing related issues I did not interrupt the flow of discussion and encouraged them to provide pertinent examples that reflected their own experiences, rather than to give exhaustive answers.

The interviews were based upon open-ended questions that aimed to provide a detailed, comprehensive picture of women's experiences, not to provide yes/no answers. They were conducted so as to allow for user-led development, offering them opportunities to generate new ideas during the interviews. I interpreted the data during the interview, which enabled me to seek clarification as necessary during each interview. Moreover, following each interview, I put aside time to reflect on the data collection experience, making notes on the interview and also recording the areas need more expansion in discussion which to some extent affecting the conduct of the following ones.

Each interview started with general questions about the woman's background. The intent was to break the ice between myself and the woman, and to help her relax by the time the substantive business of the interview had been reached (Kvale 2007). This opening also gave me an insight into each interviewee's personal history, and allowed me to gain some idea of the preconceptions on which she would build her interpretation. At that point I asked the focal question, directed at her personal perspective of her experiences. The questions that followed built on what she had said. The focal question was "Can you tell me about your antenatal / perinatal / postnatal experience?" The probes were "Can you explain to me more about...? What do you mean by....?" The aim of these questions was to encourage the woman to talk openly about their childbirth experience. Supplementary questions were asked in order to explore all the relevant issues omitted by the women. The interview questions covered their experiences and concerns during childbirth, in the light of Arab cultural beliefs and practices, their personal perspectives on the issues relevant to those experiences, and suggestions for the improvement of maternity services in the UK.

The adoption of Heideggerian hermeneutic phenomenology locates the researcher alongside the participants within the research process (Gadamer 1989). I played a pivotal role in data collection, as I sometimes led the women to explore some of the issues just referred to. I guided the discussions, generally at first and then more specifically, seeking the development of areas of interest as it became necessary. I recognised that however well the interviews were conducted, their recording and analysis would determine the quality of the result. Leading questions were only posed in order to elicit information and to clarify any issue raised during the interview (Kvale 2007). The reliability of the interviews was thereby enhanced.

A variety of general techniques was required to achieve successful interviews. In the case of my interviews, the respondent's freedom to choose the interview venue, give her real responses and maintain a comfortable atmosphere contributed to open conversations and a willingness to reveal what she wanted to say. All the participants were interviewed in their own homes except for one woman, who asked for the antenatal interview (first interview) and postnatal interview (third interview) to be conducted in her restaurant after 10pm, as the workload was less. The perinatal interview (second interview) was conducted in her home. Six women asked to be interviewed while their husbands were away. The other two women wanted their interviews to be in the evening while their husbands were home and could take

care of the children. Such issues were taken into account and the impact considered when interpreting and analysing the data. For example, the presence of the husband in the house during the interview gave me a view of the relationship between the woman and her husband and how this was reflected in the children's attachment to their fathers. The other women's children disturbed us a lot during the interviews, and the husbands did not support and help their wives. This helped me in the analysis of each woman's idiographic experience.

The participants were encouraged to describe their experiences of childbirth. All of them were asked whether they wanted to be interviewed in Arabic or English. All chose Arabic, as they felt they could comprehend and express their feelings and thoughts more freely in their native language.

Interviews ideally took place with no one else present; although in some cases the woman's own children were there. This posed a challenge, as these women stopped the interviews many times to respond to their children. It was difficult for us to concentrate on the conversation in these circumstances, which forced me to finish the interview earlier than anticipated. In subsequent interviews with these mothers, some relevant issues were discussed again in more detail. At the request of the participants, the mothers of two of the women attended the perinatal interview. One of the mothers was keen to discuss Arab cultural beliefs during childbirth and her perspectives on the husband's role in childbirth. The other attended the delivery of her daughter and she participated in the interview regarding the experience of labour.

Through my interviewing style I built a rapport with the women and they appeared to trust me as an interviewer. They discerned the importance of their role in this study, as they were helping midwives to understand something important about their lives. The discussions resembled conversations more than formal interviews, allowing women to talk freely about their experiences and all the things they were concerned about. I also respected the women's cultural backgrounds, beliefs and values. The interviewees were viewed as discerning individuals, with the ability of self-interpretation, which is a hermeneutic attribute (Gadamer 1989). A trusting relationship was established between the participants and me; after the first interview we constantly phoned each other. Later these women sometimes consulted me on personal issues and sought my help in resolving some problems, which I appreciated very

much, noticing incidentally how much they were in need of someone they could trust to talk to.

Before each interview commenced, I had a cup of tea with the woman and we talked informally, as is the custom in Arab Muslim society. These subcultural “gossip sessions” gave me an initial rapport with the women, as well as relaxing them before the interview commenced, and chatting informally without the tape running. It also offered an invaluable and effective additional stimulus for conversation during the interviews themselves. These informal conversations helped me interpret the data, especially as regards the analysis of each woman’s experience. I documented these conversations in my diary immediately after the interview, with the permission of the women, in order to add them to my field notes.

After the first interview I maintained weekly telephone contact with the participants so that the second interview could be arranged within one or two weeks of the woman giving birth to her baby. The date for the third interview was arranged at the end of the second, and was conducted within one to three months postpartum.

The women were told that the duration of each interview was anticipated to be 60 to 90 minutes, and that the interviews were to be audiotaped with their permission. I explained to them the need to audiotape the interview, as the precise record of their experiences would assist me with interpretation and analysis, since I would be able to hear the way in which their words were said, the woman’s tone, and her emphasis on particular words.

One woman did not feel comfortable being audiotaped; I respected her request and the interview was written down verbatim during the meeting. Another woman reported that she had not asked her husband’s permission for audiotaping the interview, and so her antenatal interview was not taped. The following interviews were taped after her husband had granted his permission. In Arab culture the woman’s voice is often perceived to be a private issue; not all Arabs accept that the female’s voice should be heard by men. I assured the women that the interviews would only be heard by myself and my (female) supervisors. The women agreed that I could include quotations from their interviews in my thesis.

For cultural reasons I kept in contact with the participants even after I had finished collection of the data. Because the women generously gave me their time, I could not restrict the

relationship to the interviews because they would believe that I had only met them out of self-interest, which they would have perceived as a kind of self-seeking. I used the rapport created between us to formulate a profile of each woman, which helped me in the interpretation of their idiographic experiences.

The fact that I shared a linguistic, religious and closely related cultural background with my participants facilitated my understanding of their experiences. My background and my pre-existing knowledge of Arab culture played a role in the study. Interviewing women in their native language was also important. Language is considered part of one's culture and is reflected in it; the loss of language can result in the loss of the culture itself (Benner, 1994). A gulf between the researcher's and the informant's backgrounds may cause problems of understanding and interpretation (Benner 1994). Speaking in the women's mother tongue and being familiar with their cultural backgrounds facilitated the discussions with the women, giving me the chance to reflect on their experiences in an integral way in English to midwives with different languages and cultural backgrounds.

All the women were good narrators, and were pleased to be given the chance to talk about their experiences of childbirth, with all its vicissitudes, and the concerns and challenges they faced. Many women were pleased to have the opportunity to share their personal perspectives on and feelings regarding these experiences with me, experiences I myself had undergone beforehand, as mentioned previously. On the other hand I constantly stressed that the aim of the interviews was to obtain a deep understanding of some of the challenges involved. I emphasised this especially during the first interviews, as they were wary of revealing any personal details about their past or current lives, as they still perceived me at that stage as a stranger. I overcame these challenges by establishing a relationship based on trust, a relationship enhanced by the informality of the conversation and the absence of a critical attitude. Before leaving I informed participants that if they thought of anything else they could call me. One woman called me two days after her postnatal interview and discussed some important aspects of her experience with me that she had forgotten to explore during the interview.

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The data collection process was finished within eleven months. The first interview was conducted in August 2007 and the last in July 2008. A total of 26 interviews were carried out, only 22 of which are included, as mentioned previously.

## **4.9 Field Notes**

I kept a research diary, and after each interview I immediately documented all the interview's key points as well as its atmosphere. I also listened to the audiotape within two days, and documented my reflections about what had been said. This diary contained the extensive notes I took during the data collection process, notes that reflected my personal interpretative comments and that would assist me during analysis. As Silverman argues, "in making field notes, one is not simply recording data but also analysing them" (Silverman 2000 p126).

My field notes consisted of descriptive data for each woman, the informal conversation before the commencement of audio-taping, and my personal thoughts and ideas. These notes supplied me with contextual data on each woman's life, data that was important in my methodology. Heidegger asserts that one's existence is influenced by one's past, present and future (Heidegger 1962). Thus, to understand the women's experiences I required an understanding of their backgrounds. My field notes played a valuable role in providing me with this information. Moreover, they helped me during the analysis and interpretation process. They were useful when I attempted to revisit the data several months after I had completed the interviews.

## **4.10 Transcription**

Audiotapes were duplicated and kept in a locked cupboard in many secure places and one copy was then transcribed. Transcription started as soon as possible after each interview. Firstly, all interviews were transcribed into Arabic, and then translated into English using a word processing package (Microsoft Office Word version 2003). When transcribed, each transcript was changed into a rich text file before transfer into the NVivo 2 program. The interviewees were asked to read the transcribed interviews and make comments, further enhancing the credibility of the data collected. No one asked me to omit anything from the transcript. An Arab-speaking colleague assisted in checking the translation of the information sheets and the consent form from English into Arabic, and also confirmed that the interview transcript translation from Arabic to English was accurate. After transcribing all interviews, I

read and reread the text until I had gained an in-depth insight of each woman's experience, thus beginning the process of immersing myself in the data preparatory to analysing and interpreting it. I believe that transcribing and translating the interviews gave me the opportunity to immerse myself in the data. The women's words always resounded in my mind. I felt as if I lived with them, an experience that made the analytical process easier.

## **4.11 Coding**

The interviews were intended to explore the women's personal experiences of childbirth in the UK. I discerned the meanings in the transcripts and coded them in an open way, after which I carried out progressively selective coding.

To reveal and name the categories, Strauss suggests conducting analyses of each line and paragraph of the transcripts in order to find the meaning in the respondents' accounts (Strauss 1987). The process of open coding and then clustering the generated categories into themes is defined as the process of axial coding. The qualitative data analysis software 'NVivo 2' was used in this study. I was aware that this software would not point the codes or formulate the memos by which to articulate the phenomena, but it is a tool with which to organise the codes (St John and Johnson, 2000). In commencing the coding, I thought carefully about what the passage is saying and what it is about. I followed type codes (see appendix 12) describing how the paragraphs are named under nodes representing exactly what the paragraph is talking about. In this stage I only grouped the data under 105 "free nodes". An example of the resulting code framework is included as appendix (13). After constructing this list I started shaping them into a more efficient system, organising the data into preliminary "tree" or parent nodes (see Appendix 14).

## **4.12 The Process of Data Analysis**

The goal of the analysis was to interpret the meanings shared between the interviewees as they recounted their lived experiences to develop an ontological understanding of migrant Arabic Muslim women during childbirth in their own contexts. Heidegger (1962) asserted that understanding and interpretation are requisite means of Being-in-the-World. I



acknowledge that, as a researcher as well as an migrant Arabic Muslim woman, I approached the interviews with the women, the analysis of their words and eventually the development of this thesis, in the context of the world, which I cannot negate in order to conduct this study. Consequently, I did not try to eliminate the influence of my pre-understanding or commence this study with a totally open mind. My pre-understandings of the experiences of the women had coalesced to enrich the subsequent analysis.

The data were analysed using the principles of Gadamer (1975), some of the ideas of Smith (2003) ideas and the software program NVivo 2. Then I used my own way of analysing the data. Guidance offered by Smith was helpful during the data analysis phase, while the outcome is unique because of the fusion of horizons between the researcher's background and the data emerging from the women's interviews (Smith 2004, Gadamer 1989).

My analysis began during the data collection process. For instance, in semi-structured interviews I started to analyse what the woman said in order to plan for the next question. Moreover, I recorded some thoughts after each interview as analytical field notes, and then compared them to the interview transcripts. The analysis commenced with a process of self-reflection as the preparatory phase of research analysis. This included writing down these reflections for reference during analysis. These assumptions are embedded and essential to interpretative analysis. However, when there is an abundant amount of data, thorough and systematic analysis is needed.

The data analysis method used draws on the choice of methodology and data generation process. At the same time it should be recognised that there is no single, definitive way to do qualitative analysis. "Qualitative analysis is inevitably a personal process and the analysis itself is the interpretative work which the investigator does at each of the stages" (Smith and Osborn 2003 p 220).

The focus in analysing the data was on preserving the uniqueness of each lived experience and on comprehending its meaning.

I commenced the analysis by listening several times to audiotaped interviews in Arabic so as to realise the meaning of each woman's story. Moreover, I read the transcribed English interviews repeatedly, while listening to interviews in Arabic, in order to confirm that I had

found the meanings hidden in the transcribed interviews. In hermeneutic phenomenology the meaning is inherent in the text; the researcher's task is to reveal and understand this meaning rather than to explain the text. Each woman's experience was read and analysed separately so as to obtain a sense of it as a whole, and to discover similarities and differences between the experiences. The themes that emerged from this study reflected the women's experiences of childbirth and of their world. This is appropriate, given the philosophical framework of this study (Gadamer 1989).

As researchers proceed with the analysis, they find themselves adopting their own method of working. Interpretative Phenomenological Analysis (IPA) is a framework developed by Jonathan Smith that develops in-depth descriptions of human experiences. Fade (2004 p648) stresses that the purpose of IPA is to "attempt as far as possible to gain an insider perspective of the phenomenon being studied, whilst acknowledging that the researcher is the primary analytical instrument. The researcher's beliefs are not seen as biases to be eliminated but rather as being necessary for making sense of the experience of other individual". In this study I used some of Smith's ideas and situated these to my way of analysis.

IPA is concerned with cognition - with what participants think or believe about the experience under study. During the analytical process the researcher therefore tries to define the participants' thoughts, thoughts that are somewhat incoherent at the transcription stage. Smith (2004) argues that the research exercise is a dynamic process. The researcher tries to enter the participant's personal world, but this cannot be fully achieved: it depends on – and is complicated by – the researcher's own preconceptions.

Smith (2003) presents two approaches to IPA. The basic method is the idiographic case-study approach suitable for small samples of up to ten participants; this allows the researcher to describe a single case in great depth and to explore the themes shared between the participants' experiences. The second approach is the theory building one; this is useful when the desired outcome is a theoretical explanation or the formulation of a model. The aim of this study being to give in-depth descriptive interpretations of the experience of migrant Arab Muslim women during their childbirth in the UK, I adopted some steps of the idiographic case-study to guide me in analysing the data. I looked in detail at the transcript of one interview before consolidating the next.

I will now explain in detail the steps used for carrying out thematic analysis, beginning with my treatment of the first transcript.

### **Looking for nodes in the first interview**

I read the transcript several times to get an overall sense of the data, and used keywords to note any striking issues in the paragraph by coding it in free node (see Appendix 12). I then continued coding the other interviews using the master-nodes list from the first interview and adding any new nodes arising from the rest. At this stage, Smith (2003 p222) comments that “all the transcript is treated as potential data and no attempt is made to omit or select particular passages for special attention”.

### **Looking for connections**

I looked for connections between the free nodes in order to cluster them in a meaningful way. I abstracted the free nodes that emerged from the data and organised them into tree nodes. Some nodes were clustered together, some were regarded as superordinate concepts and some acted as magnets drawing others to them. As new clusters of nodes emerged, I followed Smith’s advice to check with the transcript to make sure the connections between the nodes accorded with what the participant actually said. This stage requires interaction between the researcher’s own interpretative resources and the text so as to extract ideas regarding the participant’s responses. At this stage I revisited the transcript with one click by using the NVivo 2 program in each node to make sure that I had clustered them in a meaningful way (see Appendix 13 for the connection between the parent node and their subordinates). At this point some nodes from the initial list were deleted if they did not match the structure of the nodes in the master list. These deleted nodes are discussed in detail in the women’s idiographic experience because they do not fit within a coherent way of the final master list of nodes.

After I obtained the master list of tree nodes, and through my immersion in the data, I realised that the data dealt with four main aspects: a comparison of the women’s lives in their home countries with that in their host cultures, their childbirth customs, the challenges they faced as they accessed maternity services and their comparisons of maternity care in Arabic countries with those in the UK. I then collected all the tree nodes and listed under them the four groups that represented the four aspects to which I understood the data to be referring. After that I checked the remaining free and tree nodes. I read and reread these nodes and

discovered another two aspects explored by the women during their interviews. These were the positive features of the women's experiences and the alternative models they used to cope in their new lives. After I grasped all the main areas on which the experiences were based, I started to immerse myself again in each category. For example, I collected all the nodes referring to a particular aspect, and then reread the transcripts of these nodes many times. In doing this, I eschewed electronic means, preferring to work on paper. I documented the main ideas to which the nodes referred, and then began to construct the theme for each idea, with clusters representing the whole sub-theme under each main theme. This process involved me moving between the text and my field notes. I compared the coded paragraphs under these nodes in order to obtain a meaningful description of the whole experience. This cyclical movement was repeated numerous times until the main themes and sub-themes were constructed, a process that involved many draft lists of themes, each of which was discussed with the supervisory team until the final list was produced.

After completing the interpretative analyses of all the interviews, a final master list of themes emerged. Smith (2003) argued at this stage a master list of coherently ordered themes is produced. In this final list of themes, sub-themes are subordinated to the superordinate themes that use the same idea. Each theme in the master list must be represented in the verbatim transcript in order to avoid researcher bias. The themes were not selected on the basis of their prevalence within the data but depended on other factors, as argued by Fade (2004 p650): "the decision should not be made on the basis of prevalence, but rather on the ability of the theme to illuminate other themes and on the richness and power of the extracts of data that the themes represent".

## **4.13 Presenting the Findings**

The concern in the final stage is to move from the master themes to the writing up process, and to concentrate on how to present the participants' experiences to the readers in a compelling way. Smith (2003) stressed that there is no division between the analysis and writing up; analysis continues throughout the process and in fact this is precisely when new issues often emerge.

After extracting the significant words and phrases from the women's idiographic experiences ("the parts"), there was a need to connect these back to the whole experience and look for shared meanings and for variations. In this process I found myself moving between the parts and the whole of each woman's experience, after which I found the matching sub-themes and themes. My fragmentary dialogue with the text was not a linear process but a hermeneutical, circular one. I was moving backwards and forwards through the text and continually reflecting on the data. Through entering and re-entering the hermeneutic circle, I asked myself such questions as: what was it like to live as a migrant Arab Muslim woman in the UK? How did migration influence the relationships between the couples? What challenges face migrant Arab Muslim woman in accessing maternity services? I continuously read and re-read the texts in order to make sure that I was answering these questions according to the women's own experiences and articulations of their meanings as honestly as possible. The answers to these questions allowed me to access deeper levels of the hermeneutic circle, and gave me the opportunity to fully understand the meanings these women attributed to their experiences. My interpretation began to form, and to govern the construction of my rigorous phenomenological account of the data.

Thematic analysis is a hermeneutic, interpretative process (Benner 1994). In the present study, themes were sampled in the data constructed through a process of coding, and the categories were then examined for additional cohesiveness, relationships, and any obviously contradictory viewpoints on the part of the interviewees. The interpretation of the themes is circular in nature, without beginning or end, and without hierarchy. It is therefore a process of fusing horizons, where the researcher is absorbed into the study (Gadamer 1989). In writing up the phenomenon I considered the part and the whole equally, contemplating a particular woman's experience and writing, then considering its relationship to the whole and writing some more. This constant reciprocity is typical of the hermeneutic circle; the ideas have a shininess and vitality which enables the researcher to get into the circle and maintain a dialogue with the text in order to produce new understandings (Gadamer, 1989). This is the method I used in this thesis.

I have sought to reveal to the reader the feelings, responses and interpretations of migrant Arab Muslim women during the period surrounding their childbirth in the UK. In the following two chapters I present the findings of this study. Chapter five will firstly discuss each woman's idiographic experience, the aim being to assist the reader to know the women

participated in the study more closely, give some idea of the distinctiveness of each one, and then the aspects they have in common that could contribute to thematic analysis. By providing an in-depth description of the childbirth experience of each woman, the reader could demonstrate the process of data analysis and interpretation I used, and to also ‘set the scene’ for the thematic analysis chapter.

In chapter Six I discuss the main themes and sub-themes. Six main themes emerged from the interviews: displacement and reformation of the self; by the grace of God; the vulnerable woman; adaptation to the new culture; dissonance between two maternity health systems and the valuable experience. These themes reflected the women’s lived experiences of their childbirth in the UK. The themes present a contextual background to the essence of the phenomenon. I chose this way to present the findings as it represented the totality of the experience from the viewpoint of the participants from which I was able to drive a meaningful phenomenological description of the research question. Each of these themes revealed the essence of meaning of women experience of childbirth in a new world.

## **4.14 Achieving Rigour**

Qualitative research is considered by some as a “soft option” and lacking in scientific rigour because of the possibility of researcher bias (Whitehead 2004 p512). Rigour is clearly considered to be the key for research success, the researcher rather than the reader being responsible for ensuring it (Rolfe 2006). The study must judge by readers as rigour in a reflexive way, and they have to decide if result is credible. The criteria of reflexivity and validity are used in qualitative research to ensure rigor when reviewing literature.

### ***4.14.1 Reflexivity***

Reflexivity implies self-criticism and self-appraisal, with an understanding of the importance of context in interpretive research. Fade (2004) views it as an optional tool that permits researchers to formally acknowledge their interpretative role, rather than considering it as an essential technique to avoid bias. I documented my journey of collection and interpretation of data through self-reflection and feedback from my supervisory team on my transcribed

interviews and my analysis. Moreover, my first supervisor interviewed me about my own experience of childbirth as an immigrant woman. The aim was to assist in developing my interview technique and to obtain deep insights into the women's experiences, as well as encouraging me to reflect on my propositions. This opportunity allowed some of my propositions to shine, expanding my awareness of the various possible interpretations of the experiences offered by the women, interpretations that may be deeper and more expansive than mine. Also, it assist me in realising the differences between myself giving birth in an Arabic country and these women, giving birth in a country with such different cultural and religious beliefs.

In addition I described in the literature review chapter the issue of women in Arab countries, so that the voices of Arab Muslim women could be heard in their context, in their life world. Readers will thus be able to verify their voices through my interpretation, and some new understandings of their experience will be gained.

#### ***4.14.2 Validity***

Validity is another word of truth (Silverman 2000). The issue of validity in qualitative research is linked to trustworthiness, which covers credibility, transferability and dependability (Rolfe 2006).

##### **4.14.2.1 Credibility**

Credibility refers to the truth, value or believability of the findings through prolonged engagement with the data. The fundamental concept of the phenomenological approach is that there are many meanings of the phenomenon under study. In order to enhance credibility in qualitative research, Moules (2002) suggests offering the text to other readers who can open the interpretations up further.

To ensure credibility in my study, I was aware of the necessity of seeking other possible meanings in the data. I discussed my interpretation with my supervisory team, and as the themes emerged they agreed with my interpretation. Throughout the writing process I took their comments into consideration, and they approved of my analysis of the women's experiences. On the other hand, I returned the interview transcripts to each woman, both for their further comments and to confirm that it accurately reflected the essence of their lived

experience, thereby enhancing the trustworthiness of the data (Denzin and Lincoln 2003). In doing this I acknowledged that their interpretation of their experiences might differ from mine. I also discussed my findings with the participants.

In hermeneutic phenomenology, the researcher's influence is considered as a problem in interpreting the data (Whitehead 2004). Researchers must be aware of the potential effect of their personal and social backgrounds. In this study some information about my background was given in order to allow readers to judge the study's credibility for themselves.

#### **4.14.2.2 Transferability**

Transferability is the term used instead of applicability (Seale 1999). It depends on the degree of similarity between two contexts. The original context must be described adequately so that the judgement of transferability can be made by readers. Koch (2006) suggests that readers should be provided with sufficient contextual information to make similar judgements possible by others. I have provided readers with full and clear descriptions of the social contexts of the women, so that they have a sense of their life experiences and can compare them. Every theme in my analysis chapter will also be supported by quotes from the women's interviews.

#### **4.14.2.3 Dependability**

The term dependability in qualitative research closely corresponds to the notion of reliability in quantitative research (Golafshani 2003). In the latter, the term "reliability" means that the results of the study can be replicated in identical conditions. The interview method used in qualitative research makes it difficult to achieve reliability because the researcher's interpretation plays a role in the results, as do the changing views of participants. Golafshani (2003) argues that the issue of reliability has no effect on the value of qualitative research. Also using Heideggerian hermeneutic phenomenology is about the engagement of the researcher with the data which makes interpretation unique. My choice of hermeneutic approach was not to generalize my finding to defined populations. My intention was to understand the meaning of being a migrant Arab Muslim woman who had her childbirth in the UK from the perspective of the woman. These meaning could be different from woman to woman, the variety of meanings would enrich our understanding of the phenomena.



This study used the Heideggerian hermeneutic phenomenological approach, the researcher's horizons counting as the key element. I therefore acknowledged my historical, cultural and personal background as the study progressed. I was aware of my pre-understanding that enabled me to establish a rapport with the women throughout the research process; my prior knowledge also helped me understand their attitudes, beliefs and cultural values of their experiences of childbirth.

I also valued the women's ability as self-interpreters; I respected their recollections and reflections on what happened. I tried to be open as possible, both for myself and towards the women's perspectives, in order to gain new understandings of their experiences.

## **4.15 Conclusion**

In this chapter I have addressed the methods used in this study, including recruitment of the women, interview technique, data analysis, achieving rigour and ethical issues. I have also described how the methods I used are in accordance with the context of Heideggerian phenomenology. In the following two chapters I will present the findings of this study, obtained by an in-depth and rigorous process of hermeneutical phenomenological interpretation.

## **CHAPTER FIVE**

### **WOMEN'S IDIOGRAPHIC EXPERIENCES**

#### **5.1 Introduction**

The phenomenological approach is concerned with an individual's perceptions or their account of events to attempt to reveal the hidden meaning of that event. The purpose of this study is to get close to the women's personal world, to find meaning in that world and to understand the experience of migrant Arab Muslim women during their childbirth in the UK from their own perspectives. In order to make sense of this world, a process of interpretative activity is required.

By giving the women the opportunity to recount their childbirth experiences in detail, I obtained a detailed, vibrant description of the phenomenon, which had not been discussed at this depth before. By describing the experience fully and richly, the experience was assimilated at a deeper level. By encouraging the women to narrate their experiences, they revealed their hidden and hitherto often unexplored meanings. Clients' viewpoints on healthcare are an important source of information in assessing and improving the quality of care delivered (Todres and Holloway 2004).

The findings of this study are presented in the following two chapters, which are based on Heideggerian hermeneutic phenomenology. They will give healthcare providers involved in the care of migrant Arab Muslim women during childbirth precious insights, and provide midwives caring for this group of women new perspectives that enhance appropriate midwifery.

The childbirth experiences for eight women are presented to allow readers to obtain an insight into the participants' world, and to gain more understanding from the stories narrated by the people who have lived these experiences. During face-to-face conversation, they have attributed meaning to their experiences of being migrant Arab Muslim woman experiencing childbirth in the UK. As midwives, those stories can broaden our horizons and supply us with a greater understanding of the women's world.

In this chapter I introduce an overview of women's experiences so that the reader can "get to know" these women more closely. The experiences are presented as individuals or "parts" before relating them to the "whole" as it is linked to the methodology underpinning this study (Van Manen, 1990). The significant sentences, perceptions and meanings from ideographic experiences (the parts) will be related back to the whole in thematic analysis to revealed shared meanings, which will be presented in the next chapter.

The experiences are presented in the order in which the women were interviewed. As a researcher my position in the hermeneutic circle permitted me to interpret the data from my historical background. My pre-understanding enables me to grasp the significance of the experience, and to illustrate it in a way meaningful to midwives.

## **5.2 Setting the Scene to Reveal the Phenomenon**

In order to answer the research question "What does it mean to be a migrant Arab Muslim woman experiencing childbirth in the UK?" the participants talked about the whole experience of childbirth. Thus, women needed to 'set the scene' in order to discuss and describe the meaning of that experience. They talked first about their background and why they migrated to the UK, and recollected how they adapted to life in this country; then they described in detail their access to maternity services and their feelings when they knew they were pregnant. They also compared maternity services here with those in their own countries. They recalled their experience of labour with all its vicissitudes. They gave a full picture of how they coped during the postnatal period, and how their husbands acted during childbirth. In this way, each woman gave a unique description of her childbirth experience, which enabled me to reach an interpretation drawing on my own perspectives as well as each woman individual experience.

## **5.3 Overview of the Women Who Participated in the Study**

It should be noted that experiences of migration vary, taking different courses and resulting in different consequences depending on the conditions under which they take place. It should be understood that the experiences communicated by the women in this study are not intended to

be representative of all Arab migrant women who migrate to the UK, and whose experiences might differ from the ones presented here. For example, there are women who have been in this country for only a few months, and others who migrated several years ago. Moreover, there are women who know that they will stay permanently, those who know that they are going back to their countries after certain periods of time, and those who have not yet decided what they will do.

Data was gathered from 22 interviews with eight women. Seven women completed all three interviews (antenatal, perinatal, postnatal) and one woman completed the antenatal interview only. Analysis of personal details revealed variations in the ages, parity, length of time in the UK and the country of origin within the group of participants (see table 6.1) There is variation in Arabic countries, which fall culturally into four of the five regions of Arabic countries (see chapter 1 page 35). While the majority of the women migrated to the UK for educational reasons, three accompanied their husbands in order to improve their socioeconomic status. Five women lived in the UK temporarily and three were permanent residents. Six participants were from the middle classes in their own countries, and two women, (from Saudi Arabia), were from a high socioeconomic group as a result of the oil revenues on the population of these countries. Four women graduated from high school and four from college before migrating. Two of the college graduates were completing their PhD studies in the UK. It should therefore be born in mind that this analysis has emerged from the experiences of the particular group of women under study. They share the following characteristics.

**Table ( 5.1 ) Personal Details of Interviewees**

<b>Name (pseudonym)</b>	<b>Age</b>	<b>Country of origin</b>	<b>Reason for migration</b>	<b>Years of residence in the UK</b>	<b>Pariety</b>	<b>Time of the first interview</b>	<b>Time of the second interview</b>	<b>Time of the 3<sup>rd</sup> interview</b>
Hadeel	23 years	Jordan	PhD study	2 years	G2P0	32 weeks gestation	1week postnatal	12 weeks postnatal
Rahma	28 years	Jordan	PhD study	1 year	G4P2	36 weeks gestation	10 days postnatal	10 weeks postnatal
Kawther	25 years	Saudi Arabia	PhD study	1 year	G3P1	34 weeks gestation	12 days postnatal	11 weeks postnatal
Amal	23 years	Syria	Working	3 years	G2P1	33 weeks gestation	8 days postnatal	12 weeks postnatal

Amina	More than mid thirty	Algeria	Working	5 years	G2P1	38weeks gestation	14 days postnatal	12 weeks postnatal
Zahra	36 years	Sudan	Working	9 years	G5P4	33 weeks gestation		
Fatima	27 years	Saudi Arabia	PhD study	2 years	G2P2	35 weeks gestation	8days postnatal	13 weeks postnatal
Hiba	22 years	Egypt	PhD study	1 year	G1P0	30 weeks gestation	7 days postnatal	12 weeks postnatal

All the participants were accompanied by their husbands, and they had not suffered any economic problems: all those who migrated to the UK as students received funding from their own government, while the husbands of the other three worked in lucrative jobs - one as a medical consultant and the other two running their own businesses. The study sample did not include refugees or asylum seekers. It is acknowledged that refugees are likely to have additional challenges to their health and access to healthcare and this requires further study. Assessment of each woman's English language skills was based on what they told me. Two women (Hadeel and Hiba) said that they could manage to communicate in normal situations but found it difficult to understand medical terms, one woman (Amina) couldn't communicate in English at all, and another three (Kawther, Fatima and Amal) could understand the midwife but did not have the grammatical skills to answer. The remaining two (Rahma and Zahra) participants had no difficulty in communicating.

All the women in this study wore the *hijab*, the traditional head scarf worn by Muslim women to cover their hair. One woman (Fatima) also wore the *nikab*, the face covering that leaves only the eyes visible.

Another important issue that should be mentioned before presenting the women's idiographic experiences is that the women in the study were followed up by private gynecologists in their own countries, because the standard of care in the public sector in those countries is below the standard, except for the Gulf countries. As a midwife I worked in public hospitals in Jordan and in one Gulf country. I noticed the difference in the standard of care as a result of oil revenues, and how these rich countries maintained high standards of care for all the people living in those countries. These standards resembled those of care in the private sector in other Arabic countries.

## 5.4 Women's Idiographic Experiences

### 5.4.1 Hadeel's Experience

Hadeel was a 23 year old Jordanian woman. She migrated to the UK immediately after her marriage in order to join her husband, who was studying in the UK. The first interview was in her 32<sup>nd</sup> week of pregnancy, about 14 months after she had arrived in this country.

She was the first woman I interviewed, and this experience taught me valuable lessons in conducting and interacting with the other subjects. I learnt above all to value the importance of establishing rapport and building a trusting relationship with the participants prior to their sharing of their experiences of childbirth.

Hadeel had easily adapted to life in the UK. She started her own postgraduate studies two months after her arrival here. She liked life in the UK because she perceived it as safe, the service was good and everything was easily obtainable. Moreover, she did not receive the impression that healthcare providers disapproved of her wearing a veil. The only thing she found irksome was that she was a long way from her family. She commented that maybe Arab Muslim women are wrong to be so dependent on being in close proximity to their families:

*I was not comfortable at first because I was far from my family. Maybe we are wrong because we are so close to our family. In our country the social ties are strong. When I came here all criterion were different. It was difficult for me [because there was] no one from my family around.*

She had suffered one miscarriage in the UK, and this was her second pregnancy. She found the anxiety and the pressure less this time, because during her previous pregnancy and miscarriage she had experienced a good standard of care:

*My blood group is B -ve. After miscarriage they give me an anti-D injection and informed me that after a while they would check my anti-D level because I might need another dose. The positive thing was that the anti-D was sent to my home and the*

*people who brought it to me made an appointment [for me] with the midwife to come and give me the injection. Next day the midwife gave me the injection at home. I was happy. Instead of calling me to go to hospital, the midwife came to me. I felt [that] a lot of attention and consideration [was paid to me].*

A distinctive feature of Hadeel's story was that she had a Deep Vein Thrombosis (DVT) during her pregnancy. It took ten days to diagnose her. When she felt a pain in her leg, she went to her GP who examined her and requested some blood tests. After two days the hospital asked her to come in immediately. They repeated the blood tests, started administering Heparin and the obstetrician ordered a scan of her leg to ensure that it was indeed a DVT and not a muscle spasm or bone inflammation. The radiologist, however, only scanned the upper thigh rather than the area where the pain actually was, concluding that all the veins were free of any thrombosis. When the doctor read the report he said that it might only be a muscle spasm, and not a DVT. He stopped the heparin and discharged her. She stayed at home for one day, but the pain increased and she could no longer walk on the affected leg. Her husband took her to hospital and called an Arabic obstetrician who she met during her miscarriage. He repeated the blood test and ordered a second scan, this time of the affected area. This time the head of department did the scan, and again the result was no thrombosis. Nevertheless the Arabic doctor started giving her heparin again. He said that clinically it was a DVT and he was not convinced by the previous scans. He ordered a third scan, and told them that he wanted to prove that it was DVT. This time a consultant in the scanning department performed the scan. He discovered two thromboses in two separate veins in the painful area. Despite all of this, Hadeel maintained a positive view of the care she received during her pregnancy, attributing the mistake to individual error rather than considering it as part of a systemic failure:

*If the first two doctors had done the scan properly they would have diagnosed it before. I thought they were experts and knew where to look, but compared with the third doctor they did the scan [too] fast.*

In the 39th week of her pregnancy Hadeel was in pain throughout the day, but because she did not attribute this to labour pains she cleaned the house, cooked, did the washing and had a bath. As the doctor instructed, she stopped taking her Heparin injection as soon as she suspected she might be in labour. That afternoon she had a visitor. She did not tell anyone

about the pain until 9pm, when she went to hospital. She gave birth to a baby boy at midnight.

Hadeel was able to recall many details of her delivery, and her overall assessment was that she was fortunate in having a supportive, cooperative and enthusiastic midwife who delivered her safely, without tearing or stitching. Even though she did not understand the medical terms the midwife used, she believed that if an Arabic midwife had delivered her, she would not have received any more explanation:

*I thought she gave me enough information about what she going to do. ...I was so happy about that. I did not have any drawbacks in communication with her, and if an Arabic midwife had delivered me, she would have done no more. Sometimes my husband translated for me. If she felt that I still did not understand, she would demonstrate it for me, or explain in a more simple way.*

Hadeel was happy with the standard of care during her pregnancy, in labour, and in the period she stayed in hospital after delivery. She commented:

*About myself, I want to repeat it again here. I told my husband that if I were to deliver in Jordan I would tell them not to give me any medicine: I want everything normal. Here I delivered without any medicine and I could stand that. The nice thing was that I felt normal after delivery and that nothing changed about me. Immediately after delivery I called my family. I talked with my father and mother. I was fully awake, I went to the bathroom and took a shower alone, and then I walked to the postpartum unit alone. I will never forget the view of my baby when they took blood from his feet and [how] his hand was in his mouth and he was looking around. If I were anaesthetised I would not know anything of what I did.*

In contrast to her satisfaction with care in antenatal and perinatal periods, Hadeel did find the postnatal period upsetting. The day she was discharged from hospital she stood in the kitchen cleaning the dishes. She felt debilitated, and received no assistance from her husband, who had been more helpful and supportive during the pregnancy and delivery:

*During my pregnancy he kept telling me, "Don't clean the house – you are tired. Leave it until tomorrow", because the baby was in my womb. When I delivered he did not say, "Leave it until tomorrow – you are tired". He said, "The good woman always keeps her home clean and tidy." I felt responsible for everything.*



After her delivery, Hadeel very much missed her mother and needed her help. However she did find that the health visitor provided some support and assistance. Hadeel felt that she replaced her mother to some extent and taught her what she needed to know.

In her final interview, Hadeel was less satisfied with one aspect of her care. During the postnatal period, Hadeel's baby became jaundiced. She informed the midwife many times of this, always to be told that it was normal. She went to her home country six weeks after delivery for a vacation and took the baby to a pediatrician for a full check up to allay her anxieties. The pediatrician immediately informed her that her baby had jaundice and an allergy to artificial milk. She was not happy that her baby had two complications that were not discovered in the UK. She commented that:

*It was not good to take everything for granted and not to take any action.... Everything is [always] normal for them. They are cold-hearted....the problem is their coldness, [their] indifference, and the deadening routine.*

Hadeel's experience of childbirth revealed that her dissatisfaction with maternity healthcare provision related to two specific episodes. The length of time it took to be diagnosed with a DVT, and the fact that if the Arab gynecologist had not been sure of the diagnosis and had insisted on obtaining the evidence of the condition, she could not say how serious her condition might have become; and secondly her baby's jaundice and milk allergy, which was swiftly discovered only in her own country by a Jordanian pediatrician. Communication was not a factor that contributed to Hadeel's dissatisfaction; my view is that this was due to the difference between the two healthcare systems in the UK and her own country, and to the cultural expectation in her home country that the pregnant women and the new baby receive extra attention - that no matter is too minor to be taken into consideration, especially within the private sector. These issues reinforced Hadeel's trust in Arab doctors. She interpreted it this way:

*I want to mention an important point. If I wanted to ask the doctor about anything he would say to ask the health visitor, and the health visitor would say to ask the doctor. Each one sent me to the other. I am sure that if I were in Jordan things will not be as bad as this. It would be resolved immediately.*

*....they must not put everything on the health visitor. I want to know what her qualifications are. Just at the point that the woman has delivered, the health visitor is responsible for her and the baby. They have to be more serious about some things instead of saying that everything is normal. The doctor coldly said that it was normal for jaundice to persist for nine weeks without the need for treatment. I am not a specialist, but when I read about it on the internet, I know it is very dangerous and can affect the baby's brain. Here they consider it normal, while in Jordan they treat it.*

#### **5.4.2 Rahma Experience**

Rahma was a Jordanian woman aged 28. She won a scholarship from the Jordanian government to do a PhD in the UK. She migrated here with her husband, daughter and son while she was three months pregnant. I interviewed her six months after her migration, when she was 36 weeks pregnant.

Rahma was happy with the conditions of her study because she only needed to meet her supervisor every two weeks rather than every day, which enabled her to stay home and take care of her children. She felt that life in the UK was easy and convenient.

Rahma was interested in nutrition and alternative medicine, so she understood much medical terminology. On the other hand she was determined to retain a positive outlook because she believed that whatever she felt would be transmitted to the baby.

Rahma had strong religious feelings, as was obvious from her talking with the midwife. She believed that God was with her, and that he would send someone to take care of her:

*When the midwife talks about her children I said I hope that God will protect them. I try to be polite when we talk. When I said to her, "You are unique", I used such spiritual words as "Angel", and she felt that my spirituality was different [from that of other women].*

She did not face any difficulties in her enrolment in the maternity health system. She was also happy with the way healthcare providers treated her:

*....you feel that they are ready to explain if you don't understand. They take the time to ensure that you do understand. They have a fantastic way of dealing with people..... They appreciate that the woman is pregnant and that she is achieving something special. This is a credit to the maternity services here.*

In the first interview, Rahma's children were with us because they refused to stay with their father. They interrupted us many times, which gave me a feeling of frustration and dissatisfaction at the end of this particular interview, because I could not explore in depth Rahma's antenatal experience. In the second interview the situation was better because the children were out of the house with their father, and I felt that in addition to dealing with the issues necessary for this second interview, I could clarify all the unfinished points of the previous one, and probe further as necessary.

Rahma was worried about delivering here, because other Arab women who had given birth in the UK had told her that:

*.... they do not stitch you up after delivery, nor do they perform any cosmetic suturing; I don't know if this is true or not.. The second concern is that I heard that they do not give a woman any anaesthetic during delivery, which worries me a lot. I heard that they will leave me to suffer alone. The third question is that during delivery, will they cover me as they do in Jordan? This is an important issue for me.*

The issues regarding cosmetic suturing and anaesthetics during delivery will be explored in detail in the next chapter, because it was mentioned by most of the women in their interviews. Here, I will only discuss the third issue, that of privacy, because Rahma was the only one to mention it. When assisting deliveries, it is usual in Arab countries for all obstetricians and midwives to cover the woman's legs and abdomen, and to keep only the vaginal area uncovered. This is an important cultural and religious matter. As a midwife I did this because it would be thought odd in our culture if we uncovered the woman. It is an important aspect of the woman's privacy and must be practised.

One of the consequences of migration for Rahma was the disruption of her social support system. While she managed to live with less support initially, she began to re-appraise her sources of help and support in late pregnancy. This re-appraisal became even more intensified

through the late part of pregnancy as she examined whether she had enough resources to face the demands of birth and the period following delivery.

*...here I'm alone with my husband and children. I'm thinking a lot about how my husband will manage with the children when I go to delivery, and how I will get out of bed after giving birth, because I'm so tired. .... there's no one to help you ....Now there is a special relationship between us, and my husband will pressure me into letting him take care of me and the baby. More negatively, I need care from my mother and sister. As an Arab, childbirth is a female issue. I need someone who empathises with me, who knows what will happen. She can help me practically; I need the touch of a mother.*

During the perinatal interview Rahma described how, once she had reached her 40<sup>th</sup> week, she felt contractions at 10 pm; at 2:30am she went to the hospital and at 5am she gave birth to a daughter. She complimented the midwife who delivered her, and explained her how she was a decent person who respected what others believed. She also spoke of the prejudice and mistreatment she suffered at the hands of another midwife she met twice during her delivery. Rahma's experience of delivery and her perceptions of pregnancy in a foreign country was affected by her interpretation of this episode:

*Frankly, I am so disappointed that I delivered here, in spite of [the fact that] the midwife was nice, but she did not compensate for the general way [I was dealt with]. I maintain that delivery in Jordan is much, much better – there is no comparison. They can say “Third World”, but they deal with people better, with humanity and kindness, and they empathise with the person, while here the apathy and indifference is perceptible.*

This quote revealed some of the cultural norms in Arabic countries: healthcare providers there are more emotional, supporting women verbally, praying in high voices and reading passages from the Quran during childbirth. They constantly touch women's heads and hands. In the UK midwives control their emotions. Her professional status is interpreted as discouraging her from showing women her real feelings. The atmosphere in Arabic hospitals is totally different. As a new mother delivering in another Arabic country, I was so happy when any female well-wishers came to visit anyone there. They would come to my room,

congratulate me and ask about my baby even though I was in a private room rather than one shared with other women; this is a cultural issue. I felt like I was with my family and in all my three deliveries I stayed for three days in the hospital, because the nurses helped me with the baby instead of discharging me and leaving me to manage alone at home. Rahma had a similar experience:

*I am grateful to God that I was not coerced into staying in hospital. In my country I stayed in hospital for two days after giving birth because they were concerned for me there. Even the cleaners were kind to you. Any woman who came to visit someone else would tap on your door and ask about you. You would feel like part of the family. I delivered in Jordan in two different hospitals, not [just] in one. [I am] grateful to God that he made my delivery easier.*

Rahma talked in detail about the differences in maternity care between the UK and Jordan. When she recalled the labour pains, they made her afraid to deliver again in the UK:

*....[the delivery] goes according to God's plan. If it is a complicated delivery, no one will help you, there is no anaesthetic during delivery, you can't sleep, and this process needs all your energy. If God does not make the delivery uncomplicated, it will be tragic. Many women suffer here when they give birth. You feel pity for these women, and they must deliver in their own country.*

*In my country.... there is no need for this intensive pain, no need to push. The baby will come out without suffering. They give her an injection and she sleeps..... The women with me in the hospital [seemed as if they] were going to die of the pain. It is unfair that they could relieve their pain but only kept looking at her. For me this delivery was the tougher one.*

Rahma did not approve of the notion that her husband should be in attendance during labour because she believed that the sight of the blood would form a barrier between them, and that this would adversely affect the relationship. So she decided beforehand not to let her husband attend the delivery, and she delivered without anyone accompanying her.

Rahma was dissatisfied with the care in the postpartum ward compared to that in her own country. She did not feel that the staff in the UK cared. They did not come frequently to check her; she felt that they wanted only to finish their job with the minimum of effort. She

said that staff in Jordan were friendly to patients, smiling all the time and constantly checking on them. She asked to be discharged only two hours after her delivery. She was glad to be back home with her children. She described postnatal care in the UK as intensive care: they remain concerned about the mother after she goes home, an attitude that is not in evidence in her country:

*It was fantastic that they took care of the woman when she got back home – it was a privilege [to be treated so well]. I hope it will be like this in Jordan.*

She had a wonderful husband, who supported and helped her in every possible way. She indicated that the support she received from her husband prevented her reaching the stage of postnatal depression, and considered his cooperation as a lifesaver:

*My husband was so cooperative. He cooked, did the washing and cleaned the house for two months after my delivery. My sole duty was to take care of the children. He was magnificent. He brought food up to the bedroom for me. The first time I went down to the first floor [was] three weeks after my delivery, and [then] only to watch television or sit with my children. I rested for two months, and after that he still helped me. He even has study like me.... He stayed with me all the time, supporting me. I did not feel lonely.*

#### **5.4.3 Kawther's Experience**

Kawther was a 25-year old woman from Saudi Arabia who migrated to the UK in 2006 nearly a year before the first interview. She was here with her husband who was a PhD student supported by a scholarship from the Saudi government. Kawther finished high school in her own country and wanted to continue her studies, or at least take English courses in the UK to improve her poor English skills which she felt placed her at a disadvantage. However she was busy with her five-year old son and was pregnant again making this difficult. Her mother came for the birth of her baby and stayed until after the postnatal period. She had no financial problems.

From my interview with Kawther, I found her to be a practical woman: she believed in doing things with the minimum of time and effort, and because of that she did not adhere to all Arabic cultural practices.

She liked to make time to go shopping or visit her friends without taking her children with her. As a result she loved life in the UK because it gives her the freedom to indulge in these activities.

Kawther was a liberal rather than a traditional Arab Muslim woman. She viewed women in Arab countries as oppressed by men and felt that women were complicit in their treatment by men there; this became evident from Kawther's recollection of her argument with her mother (who attended the perinatal interview):

*The woman is responsible for what happens to her if she behaves as my mother does. Sometimes I ask my husband to hand me something, [and] my mother immediately says to him, "No, sit, I will hand it to her." She says it is not good to let him stand while we are sitting....Here he is used to handing me things because from the beginning I let him do so. I let him depend on himself, and he does not feel upset about this. But we [i.e. Arab women] make men accustomed to not looking after us; this is our mistake. In Arabic culture there are some women who, when they get married, turn their husbands into kings: they will not let them take away the cup they have just drunk out of. Is he not a human being? can't he take the cup away himself? can't he move from his place? ....Why this discrimination? Really, this does not make me happy. Here I will not do what he asks because I don't agree with this kind of treatment. From the time we came here I didn't cook at the weekends. I said, "This is a holiday for you and for me; both of us need a rest, we can eat anything these two days." ....At first he objected, but I persisted and now he accepts reality. The man does what you let him get used to. If you are weak he will grow stronger than you. I don't want to be a copy of my mother and grandmother.*

Kawther's husband was the only child in his family. This meant that he was pampered by them, so that he became dependent on others. But with Kawther's persistence and the effect of life here, he changed. He helped her during childbirth, and took care of the children whilst she went outside the home. Her husband's new attitude revealed how adaptation to Western life permitted the nuclear family to behave in ways unacceptable in Arab countries.

Kawther was happy that she was pregnant, because for three years she had complained of primary infertility. She received treatment in Saudi Arabia for a polycystic ovary. She trusted her doctor in Saudi Arabia; he gave her Glucophage for a month and she became pregnant,

then he asked her to take Glucophage continuously, and she safely delivered her first baby. For her present pregnancy, the doctor in the UK stopped Glucophage. She was confused by the different opinions. She was uncertain about many aspects of her care during childbirth, an uncertainty that did not stem from any misunderstanding or communication problems, as her husband always translated for her. The real problem was the conflict between the obstetrician in the UK and the obstetrician in her own country:

*I went to a doctor in my country. He gave me medication to activate ovulation and I had treatment for a polycystic ovary. I took the medication for four months and came here and became pregnant. I phoned my doctor and he stopped one lot of medicine and kept me on glucophage during my pregnancy. I came here in October, and in January I was pregnant. During that time I spoke to my doctor in my own country. I don't want to be confused between [the advice I was getting from the] two doctors, so I am not following [the doctor's advice] here .... I kept taking this medication during the whole of my second pregnancy, and even after the delivery. I took it until last month. Then the doctor here stopped it and said there was no necessity for it – in fact, it may do harm during my pregnancy. But in my last pregnancy in my country I took that medicine and I delivered the baby safely. Now I don't know what to do. I will wait until summer when I am going on holiday in my country and [then I will] consult the doctors [there] about that.*

During her pregnancy she was worried about who will take care of her son during delivery, but she trusted that her husband could manage satisfactorily at home.

She described in detail how the role of her husband during her childbirth experience changed from that in Saudi Arabia, and how acculturation impacted on her relationship with her husband.

Kawther's story reflected her flexibility as an Arab Muslim woman: she could adjust to the new situation and changed some of her convictions if they did not conflict with her religious beliefs:

*I asked her about the staff during my delivery. She replied that she couldn't guarantee that all the staff would be female, and she didn't know who would be on call at that time. I told her, "Okay, write on my file that I prefer a female doctor", and she wrote in red pen "recommended female doctor and all staff to be female". I was so happy*



*that she met my request and she explained to me what the situation would be. She prepared me beforehand [for the fact that a] male doctor might examine me, and if this happened I should not be angry because she gave me the background about the conditions [i.e. had warned me about this].*

Kawther provided a very rich and vivid account of her experience. She gave clear examples of ideal midwife attributes. She was happy when the midwife explained things in English; she relied on her, not on her husband, even when he translated for her. She interpreted the midwife's behaviour as a woman-centred approach to care in maternity services in the UK, and valued eye contact between her and midwife which perceived as a kind of respect between the same sexes in Arabic countries. She also saw the midwife asking her before performing any procedure as a kind of respect; she marvelled that the midwife behaved in this way during her antenatal visits. Moreover she made comparisons between the two sets of staff in the postpartum ward, and how they behaved towards her:

*She was asking me, "Why do you want this medication? You have a sour stomach now?". I said, "If I took any other medication I will get a sour stomach, and the doctor always gives me Zantac with any medication. If you are not convinced, call the doctor", but she would not listen to me. On another shift I just told a nurse about it and she gave me the medication. That nurse [i.e. the first one] asked me lots of questions and in the end she refused to give me the medication. She only made me nervous and tense.*

Kawther was tense during her delivery because the stories she had heard from other Arabic woman about the delivery in the UK made her apprehensive. The way the midwife dealt with her, on the other hand, reassured her, particularly her use of facial expressions to convey encouragement and reassurance, However the unpleasant stories still worried her even afterwards:

*When they told me about their experiences of delivery I was scared, and when they described labour pains to me I was frightened, especially when they told me about one woman whose tear reached the cervix, and how much she suffered. I was praying that my God would aid my delivery. When I was giving birth I always remembered this woman. When I felt the contractions I started pushing. The midwife told me, "Don't push now". But I kept pushing to help her and not to get a tear. She was*

*telling my husband that I was tense, and asking him to help me relax. [She] told me to take deep breaths, but I was scared about tearing. It was my mistake....*

*The fear is the thing that affected me most. Now, when I walk, I say to myself, "I do not feel any pain", but when I go to the toilet I am afraid to push in case the stitches rupture. My husband asked the midwife about this, and she said, "I have been a midwife for thirty years and no stitches have ever come undone", but my friends told me that they might do so.*

Kawther experienced a postpartum haemorrhage following the birth of her baby because the placenta was stuck inside and required manual removal by a female doctor. This caused her to stay in hospital for three days after her delivery. She described this as the worst period of her childbirth. The standard of care in the postpartum ward was bad; the nurses were indifferent and uncooperative and did not help her with the baby. Women in Arab countries expect to receive physical care if they stay in hospital, but this was not the case in the UK. Moreover, she suffered because of the food and the shared room and toilet facilities:

*On the morning of the first day I did not have a shower. I was tired so I asked someone to help me, [but] she said, "No one can help you to take a shower. You have to do it alone, and look after yourself" ...there was blood on my dress. I came to the room at night and I was [so] tired I couldn't do anything; I did not change my clothes. She looked at me with a look that meant, "You look dirty and disgusting". She did not say exactly these words but the look in her eyes was enough....*

*No one helped me. They assumed that you would get up and take a shower on your own. They did not appreciate my state. I did not feel any kind of human sympathy in their conduct in the post delivery unit.*

Kawther recalled her delivery experience and how the labour pain affected her feelings. She appreciated the baby more this time, and was satisfied with what happened during delivery. However her view of home visits by the midwife and health visitor in the postnatal period differed from those of the other participants: she argued that because of her mother's presence, these visits were irrelevant to her. Her mother took care of her and the baby during the postpartum period. She criticised the work done in postnatal visits, as it was all to do with filling in forms. She acknowledged, however, that the health visitor was more useful and

cooperative than the midwife. She added how lonely she felt when her mother left her and she had suffered with depression:

*When my mother went I felt alone and weak. I wanted her to stay longer. I didn't want to take responsibility. [When she was here,] I took care of the baby at night, and at 5am she would take the baby and let me sleep until 11am and prepare the breakfast for me. I only took care of myself. When my mother left I [then] took full responsibility for two children....I felt depressed when my mother left me and my husband was working in his study. I felt lonely and was always crying.*

The majority of Saudi Arabian women have servants in their homes. Kawther had one even before she had any children, when she was a housewife, but that was also normal. Throughout her story she talked about the need to have servants with her and how difficult it was to adjust to the new circumstances involved in having two babies. She suffered here in that she could not get a visa for a servant because the regulations did not permit it. She had to take care of the house and two children alone. She believed she had a lower quality of life in the UK compared to that in her own country.

She was annoyed about the way migrants are treated in the UK. She was not eligible for child benefit, a state of affairs she perceived as disadvantageous for Arabs:

*We don't even get child benefit. I came here and paid for the government. The fees of one Arabic student equal the fees of four European ones. They can [also] get child benefit while I can't. It is my right to have it and I deserve it. I delivered here, I lived here and I paid tax like they did.*

By the time Kawther had finished her third interview, I felt privileged to have heard her account of her experience of childbirth. I could almost feel the challenges she faced during this period. Her argument with her mother increased my understanding of the situation of women and the dominant position of males in Arab countries. She was an inspirational example of the younger generation of women in Arab countries, who are undergoing a transition from traditionalism to modernisation.

#### ***5.4.4 Amal's Experience***

Amal was a 23-year old Syrian women who migrated to the UK after her marriage; her husband owned a restaurant, and she sometimes worked with him. She migrated to the UK more than three years ago, and was also trying to complete her undergraduate studies in Syria. She was still studying part-time there, and needed to go back to Syria twice a year for examinations. She delivered her first daughter in the UK. When her baby was seven months old she became pregnant again, and she started to worry about this new responsibility. The first interview was conducted at 36 weeks gestation in this second pregnancy.

Amal had a reasonable view of things: she saw advantages and disadvantages in every situation, and believed that one must adapt accordingly. For her, pregnancy and delivery in the UK was easier and care was better and, she perceived, more luxurious. However she felt safer and more comfortable in her own country, where society was more closely integrated with everyone on hand to help her. Conversely, she felt a greater sense of stability in the UK because her home was here. When she stayed at her in-laws in Syria, it was not her home.

In my interview with Amal I always felt that she was optimistic and that everything would go smoothly. This was reflected in her experience of childbirth, which was quite straightforward; she was the only woman who had no complaints about the standard of maternity care in the UK. She felt quite secure with the midwife who always saw her. On the other hand, she talked about healthcare providers and how they were always making things easier than they really were whenever she asked about anything:

*The advantage here is that midwives are good-humoured. They are always putting you at your ease. All the time they smile at you and make jokes, they always joke and laugh, and this is a comfort.*

When Amal started going to the Islamic centre she built many relationships with other Arab women, who subsequently supported her during her childbirth.

Amal always followed the midwife instructions and read all the booklets and pamphlets she gave to her. She believed this helped her very much, especially when attending antenatal classes, and was especially effective when she was undergoing labour pains. She recalled her previous labour, and how fortunate it was that she chose water birth. Her experience was

quite different from the complicated, painful process described to her by other women. For her it was all very easy:

*This time I will ask for water delivery. I felt that my weight was less and that I moved freely in the water. I stayed in the water for two hours. When I had contractions I cried, not from pain, but because of the thought that there would be still more painful contractions to come. When I delivered I felt that it was not difficult, as other women told me it would be. I was expecting the moment of delivery to be the most painful, as the others had described. I thought the pain would become more intense than this when the head came out; I was waiting for the next bout of pain. After I delivered I found the final moment to be not the hardest but the nicest one.*

After 40 weeks she had colic pain for two days and on the third day the contractions started. She sent her daughter to an Arab neighbour, went to hospital at 1am, and at 4:30am gave birth to a baby girl. She was in the water at 3am, but she did not feel as comfortable as she did in her first delivery. Once she was out of the water she got one strong contraction and the baby came out. After delivery she breastfed her baby, had a shower, ate one sandwich, then went home at 7am, three hours after delivering:

*When I got home I phoned my neighbour to take my daughter home. She was still sleeping, and I slept for two hours. Then I phoned them again at 9am. She was playing and I asked them to bring her around. They sent her with some breakfast for us. Frankly, my neighbours indulged me too much; they were sending me three meals a day for two weeks. My neighbours are Arab Muslims from Libya.*

Amal's mother had died before she married, so she did not resent the lack of family support, instead finding the support she received from her husband and friends enough:

*....in my first delivery I went to Syria .... for exams. That time I did not have the same support as I have now. Here all my friends and neighbours visited me. They sent me food and they took good care of me. They helped me increase my breast milk. When I was in Syria ....I was busy with exams and couldn't take care of myself and the baby. I only breastfed her and otherwise left her. I wanted to study and I ate poorly. Here everyone helped me. They sent me special foods like carauia and fenugreek to increase my milk, and advised me to drink milk. This time my milk was much better than before, perhaps because I did not need to study and because Arab women took*

*care of me. Last time I was [at home] in Syria but couldn't increase the amount of my breast milk.*

She found the home visits useful and relevant to her, and felt that the midwife and health visitor supported her in the postpartum period; they were concerned for her and very attentive in their dealings with her. On further discussion I ascertained that she was more relaxed after than before delivering, when she wondered how she would take care of two babies. When she was actually in that situation, she found that she could manage, thanks to the tremendous care she received from her husband and migrant Arab Muslims around her.

On the other hand, she laid all the responsibility for supporting the migrant wife during childbirth on the husband:

*My husband helps me in the postpartum period. The husband is the only person who can support the wife when she emigrates. When she is in her own country her mother and sisters can do that, but in a foreign country all the responsibility rests with the husband. The woman feels weak if he does not support her. It's a real problem.*

All my interviews with her gave me the impression that she was happy with all aspects of her experience, that nothing annoyed her and that she acknowledged the normality of the care offered during childbirth. She finished with some relevant advice to all women about to give birth, which I certainly very much appreciated:

*I advise all women delivering here to enjoy every moment of their childbirth, and not to consider it as a burdensome responsibility and [a cause for] dejection. I like the baby's crying. When the baby grows up I will not hear this sound again. I know that its crying sometimes annoys the mother and makes her uptight, but she must enjoy this crying. She will not hear this sound [any more] when the baby grows up and its voice changes.*

#### **5.4.5 Amina's Experience**

Amina was from Algeria and was married with one son. She did not want to tell me her age, but the interviews revealed that she was more than 35 years old. I could determine this because the medical services in the UK had asked if they could test her for Down's Syndrome, a test carried out on women aged 35 and over (she refused the test). Her husband

had worked here before her marriage, and they had subsequently emigrated here. She delivered her first baby, now five years old, in the UK.

Amina was anxious; in fact; one could go so far as to say somewhat terrified, during the first interview, conducted in her 36<sup>th</sup> week of pregnancy. She forbade the recording of the first interview until her husband gave his permission. Moreover, as well as refusing to divulge her age, she would not tell me what her husband's occupation was. As the interviewer, I sensed that Amina needed to be treated with special kindness and sensitivity, because of her suspicions regarding the interview. She soon relaxed, however, and talked freely throughout the rest of the interview process.

Upon arriving in the UK she found life to be wonderful. Her peace of mind, occasioned by the absence of problems created by her in-laws, was most congenial to her. Soon, however, other difficulties arose between her and her husband, who had emigrated here more than 20 years before (he is now in his mid-forties). She construed the cause of these problems to be the conflict between them:

*His thinking is different: he has lived here and thinks like the people here, and I still have an Algerian mentality.*

Amina was oppressed by a recurrent sense of alienation because of the multiple changes in her life including marriage, migration and the changes in her social network. These feelings mostly concerned her self-identity, her marital relationship, her social contacts and support network, and the maternity healthcare system.

Amina talked of her struggle to adapt to her new situation. One theme in her story was the rage and sadness she felt over being hurt at a time of great vulnerability during her first pregnancy. She was alone here, far from her own family, and her husband worked all day leaving her at home. Her emotional and physical depression was exacerbated by her loneliness, which was caused by isolation. Her husband was controlling and did not allow her to go outdoors without him. She had the burden of looking after her five year old son as well as undergoing this pregnancy. Her husband did not want a second child, considering it an additional, unwelcome responsibility. He consequently did not care for her during this pregnancy. Amina's morning sickness was more pronounced, and carried on for five months. She hated her husband and could not stand to see him at this time. He only went with her to

the booking visit; after which she went alone. She described in detail her struggle with poor English skills and the absence of the husband to act as translator:

*I was suffering all the time the midwives were talking to me. They asked me questions and I couldn't answer. I was worried about the baby. They decided that I should have a caesarean and that I should deliver before the date [i.e. prematurely], I don't know why. She sensed that I had problems but she couldn't help me. I was always crying and depressed, just looking desperately at her.*

Amina experienced isolation, alienation and loneliness. She needed to talk to someone who did not know her husband. She only knew one married woman, and their husbands were friends, so she could not communicate her feelings to her.

She found antenatal classes useful during her first pregnancy, but her husband refused to attend these classes this time. She compared the difference in her husband when he attended those classes:

*....the antenatal classes helped us: he changed a lot. He put what he heard into practice; he started cooking and helping me in household tasks in my first pregnancy. Now [i.e. in my second pregnancy] he doesn't. He doesn't want this pregnancy: he says, "One baby is enough".....*

Amina was a traditional Arabic woman: she believed that the man had authority over the woman, and she must always conform to his wishes.

She delivered a baby girl by elective caesarean section. Regarding her delivery experience, she reflected that the pain she underwent made her relationship with her baby stronger:

*The more you suffer having the baby, the more you appreciate him. It is not an expensive thing that you can buy from the market and that's it. No, the pregnancy and the pain you get from the operation and while breastfeeding only increases your affection for the baby.*

Amina was a religious woman. She gave a good description of her state of mind during the operation, and of the status of the mother before God:



*During the operation I prayed silently. I asked God to forgive me and I prayed for myself and all Muslims, especially my sisters, and that those of my friends who are sick would get well, that those who are infertile would bear children, and that those who are single would marry. Then I read a bit from the Qu'ran. I was not afraid to die. I believed that everything was in God's hands, and I trust God. I knew He was with me and He judged me worthy of merit and high standing because I delivered. He glorifies all women as potential mothers.*

In her description of her postnatal experience, Amina was scathing of her husband's unsupportive attitude and the way she communicated suggested she may have experienced postnatal depression:

*I was always scared and felt alone. Thank God I feel better now than I did before. I was crying, and scared of the unknown. I was always thinking about the future. I couldn't take responsibility for two children. Even when they were asleep and I was cooking, I was imagining that someone was with me in the house and that he would kill me. I really felt I would die and that no one would take care of my children. I did not tell my husband about this [because] he would not understand, [but] would say that these thoughts were from the devil. I did not tell the midwife or my friends. I was afraid they would say that I was not a good mother and that I couldn't take care of my children.*

I tried to offer her some professional help but she refused, as such a request would be perceived by Arabs as her inability to handle the responsibility of being a new or a good mother, and therefore to fulfil that position.

Amina described how her husband was working afternoons and evenings, and then spent the rest of night working at the computer. In the morning the baby was crying. Her husband objected to the noise because he wanted to sleep and her son shouted because he still did not accept the new baby. She could not bear so many simultaneous responsibilities. Her husband also resented the baby. She was exhausted after spending all day with her children, but then she started going to her friend's house and spending some time with her. Her friend subsequently started coming to her house during the day and taking care of her baby while she cleaned the house and cooked:

*In the morning I was confused and didn't know what to do. My children were crying and my husband was asking for his breakfast. He wanted to eat before he went to work. He did not want a second baby. He said that one was enough. It was more pressure on him. He wanted to sleep in the morning without being disturbed, and I was crying because of my children. During that period I slept before him. I was exhausted [after spending] all day with my children and he came in at night, had his dinner and worked on the computer. We did not meet and talk with each other.*

Amina's final reaction to her experience of childbirth was utter gratitude because she had a healthy infant. She was happy with the midwives' care, but commented that the problem was with the maternity system:

*She [the midwife] did her work fully. But I do not feel that the system is concerned with the woman. They treat what you tell them as just mundane. They do not pay attention to any problems you suffer.*

#### **5.4.6 Zahra's Experience**

Zahra, from Sudan, was in her mid thirties. She migrated to the UK over nine years ago because her husband was working and studying here. She delivered all her children, two boys and one girl, in the UK.

Her first interview was when she was 33 weeks pregnant with her fifth pregnancy. She felt uncomfortable with a tape-recorder, so notes were taken by hand. As the interview progressed, Zahra relaxed and began to talk freely.

She knew from the outset that she would stay permanently in the UK. Her relocation involved events such as marriage, childbirth in the same year as she emigrated, and maturing from late adolescence to early adulthood. The data from the interview revealed there were considerable changes in her lifestyle, most of which related to her maturity and her assumption of a new role in life upon emigration:

*I was young; I was so happy to live in the UK. It is hard for any woman who marries far from her family. She starts her life without support or advice from her family. This affected me positively: it strengthened me and heightened my individuality. The marriage experience gave me willpower and let me be independent. For the first few*

*weeks here I was shocked by the reality. I was young, and my husband studied during the day and worked at night. I missed my mother and sisters. I needed their support, but then I adjusted to the new situation.*

Zahra had planned this pregnancy because she wanted a sister for her daughter. In common with the other interviewees, Zahra talked about cultural practices during pregnancy. I received the impression that she did not adhere to Arabic sociocultural practices. She made it evident that in Arab countries they mislead pregnant women into believing that pregnancy necessitates special care:

*During this pregnancy my mother was with me and she always reminded me that I was pregnant, so when I started thinking about that I became scared. Here I learned the normality of things during pregnancy: you live as a normal person and do not need to make an extra effort. In my country there is a list of forbidden things.*

Zahra saw delivery far from her family, as well as the standard of maternity care in the UK, in a very positive light. This perspective may have been the result partly of her long stay in the UK. When the time came for the second interview, Zahra apologised and said that she was no longer interested in participating in the study. She did, however, agree that her antenatal interview be included in the study.

#### **5.4.7 Fatima's Experience**

Fatima was a 27 year old Saudi woman. She migrated to the UK with her husband two years ago and he was studying for his PhD here. At the time of the interview, Fatima was in her 35th week of pregnancy, and already had a nine year old son. Seven years ago, she went to the USA with her husband, and she stayed there for two years until he finished his Master's degree. In the USA Fatima suffered a miscarriage.

When she first came to this country she was somewhat afraid because she had heard that British people, unlike Americans, were rather racist. But when she settled down here, met people and started taking some English courses, she adapted to life and found it enjoyable.

In her country she lived with her family-in-law in the same house and she found it trying and complicated to live with all manner of interference and criticism. There, the nature of life

obliged her to consult her mother-in-law about everything she wanted to do, and to ask her advice about solving her problems.

She explained that covering up because of the demands of her Islamic culture created problems when she went out. She wears a niqab, the full veil that covers the whole face except for the eyes. People regarded her suspiciously, and sometimes made offensive comments to her. She felt that they insulted her, which made her upset. She even found some healthcare professionals were insensitive to her culture and religion:

*Once they wanted to take [a sample of] blood from me. I took my abayia off because only females were in the room. I was wearing jeans and a t-shirt under it. When the nurse saw that she said, "Wow, you can wear jeans". My husband explained that I can wear what I want under the abayia. At home I wear modern-style clothes. I only wear the abayia if I want to go outside. I said to my husband, "Do they think I come from another planet?"*

Before her current pregnancy she was treated for infertility by a British doctor. She was infertile for seven years and she sought treatment in different Arabic countries but she could not conceive. Fatima told of her suffering in seeking treatment for infertility:

*The problem is the system here. It is very slow. We waited for about a year to start the treatment. I told the doctor that I had had all these tests and I had all the results, so let's start the treatment immediately and not waste time in investigations. The doctor said, "We can't – we have a system here and we must follow it. We will start from the beginning." And they repeated all the tests I had done before.*

Fatima became pregnant after the first month of treatment. She was happier and more confident about the standard of antenatal care here than in the USA, where she had had negative experiences.

Fatima could not fully understand healthcare professionals when they talked to her, but she still did not know enough words to construct sentences and ask or answer questions. The issue of servants was also raised, a vital one for women from Saudi Arabia, where they are the norm, but UK visa regulations do not permit this.

One morning in her 39<sup>th</sup> week she felt pain similar to menstrual pain in her abdomen and back, but it did not occur to her that this was labour pain. At 5pm she saw blood, which confirmed to her that she was going into labour. She bore the pain until 1am, when she remembered what her friend told her:

*.....you should go to hospital early because they let you wait for one or two hours and you might [even] deliver in the waiting room, as happened to me.*

At that point, she went to hospital. This recollection reveals not only Fatima's awareness of the risk of being ignored after she was admitted, but also that it panicked her and made her worried, frightened and concerned for the wellbeing of herself and the baby. She told of the events surrounding her admission to the labour room. She described her condition in the waiting room: she walked along a corridor and leaned on the wall when she had a contraction. She was in pain but no one came and talked to her or examined her, they simply left her to sit in the waiting room. She waited for one hour and 15 minutes until the midwife examined her and said that she would deliver within less than two hours:

*When I went to the hospital they let me wait for one hour and 15 minutes. Then they examined me. Oh, I was in pain and no one came and talked with us. They only said to wait here. I told my husband, "Feel with me. I can't stand it anymore. Go and talk with them." They told him, "Just a minute, we will come", and no one came. I was walking in a corridor when I had contractions. I was leaning on the wall. After an hour and a quarter my husband went again and talked to them. They said, "Sorry, sorry now we are coming".*

When I interviewed her eight days after she had given birth, she appeared quite depressed. She needed much rest, she could not sit or move because of the stitches and she looked pale and exhausted. As she told her story she occasionally became tearful and cried quietly for a while before continuing.

She was happy with the way the midwife dealt with her, but the experience of labour as a whole was painful. The midwife was busy and came and went in the labour room until she delivered:

*She was busy, and she told me that everything was normal. Suddenly I felt that the baby was about to come out. My husband called her and the baby came out. I got a*

*second degree tear. She told me, "I have to call a specialist to stitch you because you have a deep tear", and another female staff member came.*

Fatima's perinatal interview was dominated by the unpleasant memories she had experienced during her labour and her stay in the postnatal ward. Fatima suffered a lot because of the staff member who stitched her badly, mistreatment that affected Fatima adversely: she became depressed after this horrible experience:

*...she dealt badly with me. When she examined me, I felt that she was splitting my skin. She gave me a local anaesthetic and started to stitch me up. The area was still not anaesthetised [however]. I felt the needle go in and out of my skin. I was telling her in Arabic to have mercy on me [because] I felt the stitching, and she was telling my husband, "I am sure your wife is abusing me". My husband told her that I couldn't talk English and that I was telling him what I felt and was not talking about her. She replied, "No, she is surely abusing me". She was shouting at me not to move. I was telling her sorry, sorry. She was not talking to me but was looking at me angrily. She was annoyed that I was talking in Arabic. She really humiliated me. My husband told her that I couldn't stand the pain any more. She said, "Don't worry; she won't die from the pain". I thanked her but she did not reply. My husband told me, "Why do you do this? You should almost kiss her hands. This is her work.... [The interviewee had tears in her eyes and could not continue.]*

Her experience in the postpartum ward was also unsatisfactory, as she perceived she was treated as an ignorant migrant woman. After she gave birth, they inserted a catheter into her for three days and the nurses gave her no help. She had to walk with the catheter to get lunch or dinner. If she did not bring it, no one would ask if she had eaten or not. Neither did they help her with the baby when she was too tired to move on the first day:

*When they sent me to the postnatal ward my baby choked and started frothing at the mouth. I rang the bell more than once until they came. I said, "Look at the baby! I can't move [him] or hold him." The nurse was uptight with me and answered curtly, "What do you want". I said angrily, "Nothing, thank you" .....*

Fatima's friends helped her regain control after her delivery. They came every day to clean the house and give the baby a bath, and they sent her three meals a day. She appreciated this and felt that Arabs were more practical here than they were at home.

Fatima's story reflects her independent nature: she described how she was annoyed and feels uncomfortable because her friends were always busying themselves around her. One week after delivery she started doing housework and cooking. Also, she was mortified that her husband helped her clean the house, which worsened her mental state:

*In my father's house my mother did everything for my father and brothers. I was brought up like this. The man is too special to do such mundane tasks as cleaning the house, and when he does I feel guilty. My husband stayed with me constantly after this searing experience of childbirth. He empathised with me. I was always crying and restless..... [Silence.....the recording is stopped because the woman starts crying.]*

Six weeks after giving birth, her husband booked for them all to fly to Saudi Arabia to improve her state of mind.

Fatima had regained her composure by the time of the postnatal interview. Her mental state had improved after she went to Saudi Arabia and stayed with her family, who relieved her of her worries; she commented that the best part of her postnatal experience was the visits by health visitors.

#### ***5.4.8 Hiba's Experience***

Hiba was a 22 year old primigravida Egyptian woman. When she migrated to the UK 14 months previously with her new husband, she had recently graduated as a civil engineer. Her husband was studying for a PhD funded by a university in Egypt. At the time of the antenatal interview she was 30 weeks pregnant.

Hiba was the only daughter in her family. She had two brothers, and was the first of her siblings to marry. She said that life in Egypt was not comparable to life in the UK: the former was more of a child's life, in stark contrast to the latter. The transition was relatively sudden. It was hard on her and her family to accept that they were separated by a great distance. She

suffered from isolation when she emigrated here. She was always crying before her pregnancy, and this only became worse after she conceived.

Hiba liked to stay at home. Friends were not essential to her. Her family was the foundation of her life; they were close to her and she was very much attached to them. When she came to the UK and did not find anyone to be with or talk to, it made her depressed. She expected life to be more enjoyable than this. She attributed her feelings to the fact that she stayed home; if she had worked or studied here, she would enjoy life.

She was happy that she became pregnant, because she had been eagerly awaiting this pregnancy. She was worried that she had not become pregnant within six months of their marriage. The people around her worried her with their questions and comments: they put her under pressure, and told her to see an obstetrician for treatment, but their childless condition did not concern her and her husband.

In the second month of her pregnancy she went back to Egypt and stayed there for two months. She observed the difference in standards of care between the two countries:

*On the first visit the midwife told me, "You are not sick, you are pregnant". In Egypt they let you feel that you are sick and that this is abnormal, which is why they pay more attention to it.*

She was happy with the way the midwife dealt with her, and with the beneficial effect of her manner, especially on migrant women:

*.....the midwife was friendlier with me. She talked more about various subjects and listened to me. This is better for the pregnant woman's confidence. In the UK there is no one to talk with, so it is nice to find someone to talk to about your pregnancy. It would be difficult if they only gave short answers to your questions.... The midwife always talks directly to me, and this is nice. You feel that you are the important one, while in Egypt they talk to the husband, not to you. You are the weaker one, and this is the upsetting thing.*

Through her whole experience of childbirth, Hiba's husband provided her with enormous comfort and support. She compared Arabic husbands here and in their own countries in great detail:



*My friends in Egypt stay with their mothers during pregnancy. Their husbands come in at night from work and their mothers take them to the obstetrician for check ups. The husband does not share the pregnancy with her. My husband here is more sympathetic to me. He asks what he can do for me, and helps me with the housework. I told him I was sure that if he were in Egypt he would never help me around the house.*

Hiba's experience of pregnancy confirms those of all migrant Arab women – for example, their greater independence and their willingness to take full responsibility for themselves, and how maternity services in the UK encourage them to find out about everything involved in pregnancy. She also noted that the standards of care are the same for everyone in the UK, while in Egypt only relatively rich people receive a high standard of care.

Hiba's mother came two weeks before the delivery and stayed one month afterwards; both then returned to Egypt for six weeks. Hiba's mother was present throughout the perinatal interview and she took an active part in the discussion, as she attended the delivery with Hiba's husband.

Hiba was very apprehensive about giving birth, which affected her cooperation during the delivery. When the midwife wanted to examine her vagina, she screamed until the midwife removed her hand and discontinued the examination. Then the membrane ruptured, the liquor was stained with meconium. The midwife told Hiba that the baby's heart rate was low and that they would have to deliver her quickly. The doctor was called and immediately delivered the baby using forceps. Hiba suffered a postpartum haemorrhage and her haemoglobin level dropped to 7.3. A urinary catheter was inserted for twelve hours, and Hiba was kept on the delivery suite under observation for several hours after the birth. An African midwife cared for her during this time:

*She was not the one who delivered me. This one was a rough African. I tried to breastfeed the baby but there was no milk, [so] she gave me bottled milk to feed the baby with. My husband told her that we didn't know how to feed it, [because] this was our first baby. She said that this was the first baby for her mother also....She said that I had to clean myself. My mother wiped me and gave me a sanitary napkin. I couldn't move to go to the toilet. I felt strange that I delivered in my jacket. My mother noticed this and took it off. They did not give me a [hospital] gown.*

Hiba also told of her frustration in trying to communicate effectively while she was delivering:

*They are unemotional and practical here, while we are sentimental by nature. She was telling me that the baby was distress and that we had to deliver it immediately, which was true, but she was saying this to a woman who was delivering and in pain. This is my baby – what more could I do? She demoralised me. I understood what she said but I couldn't tell her what I wanted.*

When Hiba had finished telling me the story of her delivery, I felt that I had been privileged to hear it. I could almost feel her irritation at the midwives during and after the delivery.

She spoke of her dissatisfaction about her experience of delivery and stressed that midwives must recognise the differences between Arabic and British women. She spoke of the differences in their bodies, and recalled how she regarded her labour pains as intolerable, as do all Arab women, who come from hot countries such as those in the Gulf region. This was apparent in the suffering of the two women from Saudi Arabia, and also that of Hiba herself, who had lived in Cairo, an overcrowded city in which it is difficult to walk. She also referred to different fitness levels, offering an explanation for how British and Arabic women were therefore different in labour:

*They are physically stronger than us. They exercise continuously. Their bodies are different than ours. Here they walk, while in Arabic countries we always go by car. Walking makes the body more flexible and they can tolerate labour pains more than we can. The midwives do not consider these differences when dealing with Arab women.*

After the perinatal interview, Hiba decided that she would not deliver again in the UK. She felt she would be more secure if an Egyptian doctor were to deliver her. But her view changed totally when she went to Egypt and stayed there for six weeks with access to the maternity and child healthcare there. She now understood the philosophy of maternity services in the UK, and has learned to appreciate it.

The problems she suffered after delivery made Hiba depressed. She had flat nipples and could not breastfeed the baby. She also got diarrhea, which caused inflammation in the genital area so that the stitches did not heal. Moreover, she got an allergy and grazed skin – her entire body looked as though it had been burned. She overcame these difficulties, however, with her husband's support and her mother's presence. She considered these as lifesaving means for any new mother to regain control of her life:

*...the presence of the mother is essential after delivery, not only to give physical but also mental help. Some new mothers will not have stitches and they can do things by themselves, but after delivery you will have a nervous breakdown. You feel a great responsibility and you will have gained weight and look ugly. No one can support you like your mother can. Your husband will be at work all day and if you were alone with the baby you couldn't manage. Your mother being there makes a big difference.*

Hiba's feelings of inadequacy were due to her inability to meet the infant's needs, especially in relation to feeding. She reported more difficulties in recognising the baby's behaviour and learning about its needs. She complained of the cessation of her breast milk and experienced intense feelings of inadequacy, struggling to regain control and retain confidence after her delivery. She decided to go back to her country with her mother one month after the delivery in order to recover from her situation, and this helped her. She then began to become more involved in the care of her baby, and the warm atmosphere around her gave her the feeling that she did a great job. While, she could not acquire this feeling when she was in the UK.

At the end of Hiba's postnatal interview, I felt that I had shared her struggles and the frustration of her attempts to regain control of her life. It made me realise that, as midwives, we believe we know best, and so we tend to dominate migrant women by imposing a predetermined solution on them. Rather than this, we must focus on the individual woman and her various requirements.

## **5.5 Initial Interpretation**

Upon revision of all the women's tapes and transcripts, I was struck by the variety of the experiences. From an ontological perspective my challenge was to reveal the meanings common to all these experiences.

The eight accounts I have presented offer a glimpse into these women's experiences of pregnancy and childbirth. The interpretation of these experiences initially revealed a number of concepts. The adaptation to life in the UK, and emergence of the nuclear family. Many of the women spoke of their independence, and described how the absence of their families' support made them very lonely during childbirth. On the other hand, they detailed the changed role of their husbands, and the effect this support had on them. Several meanings connected with "being-in-the-world" of maternity services emerged. The concept of natural care came out clearly in all accounts, as did the role of the midwife who has the requisite knowledge and skill to offer care to childbearing women. The dissonance between maternity care systems also emerged with women often referring to differences between healthcare in the UK and in Arabic countries.

Participants also clearly articulated both the positive and negative aspects of care given by the maternity services and made particular reference to postnatal home visits, which were appreciated and provided comfort and support at a time of social isolation.

## **5.6 Conclusion**

In this chapter I have given a general view of women's experiences of childbirth, and helped the reader know these women more closely. The various meanings that could be attributed to these experiences were discussed. The subsequent analysis provides the shared meaning of the experience (the whole), which proceeds from the women's experiences (the parts).

In this chapter the experiences of the participants were briefly related to each other in order to provide a context for the thesis and to situate the women in relation to one another. At the beginning of the analysis, I looked at the "parts" of the study and juxtaposed them, before examining the whole (van Manen, 1990). The development of the sub-themes and themes will be discussed in the next chapter by fusing the distinctions between the researcher's pre-understanding and the data provided by the women (Gadamer 1989), and provides an ontological description of the meaning of being a migrant Arab Muslim woman giving birth in the UK.

# CHAPTER SIX

## CHILDBIRTH EXPERIENCE IN AN UNFAMILIAR WORLD

### 6.1 Introduction

The previous chapter presented the study participant's idiographic experiences and provided an initial interpretation of them. This chapter will explore the key themes which emerged from analysis of all the data which provides an indepth understanding of what it means to be a migrant Arab Muslim woman experiencing childbirth in the UK.

Six main themes emerged from the data: displacement and reformation of the self, by the Grace of God, the vulnerable woman, adaptation to the new culture, dissonance between maternity health systems, and the valuable experience. Each of these main themes has a number of sub themes. Quotations from the women's interviews will be interspersed throughout the descriptions of each theme in order to support the interpretation.

The thematic analysis of the childbirth experience of migrant Arab Muslim women in the UK is shown in the table below.

**Table (6.1) Themes and Sub themes of the Childbirth Experience of Migrant Arab Muslim Women in the UK**

THEME	SUBTHEME
<b>Displacement and Reformation of the Self</b>	<ul style="list-style-type: none"> <li>• The emerging dominance of the nuclear family over the extended family: self-contained/ self-worth</li> <li>• Moving from dependence: self-governing /self-reliance</li> <li>• Freedom from cultural constraints: self-determination</li> <li>• Achieving peace of mind: self-</li> </ul>

	satisfaction
<b>By the Grace of God</b>	<ul style="list-style-type: none"> <li>• Safeguarding the woman</li> <li>• The ‘goddess’ mother</li> <li>• The Boon (conservation, acceptance, systematising)</li> <li>• Closer to God: self-purification</li> <li>• The price of mothering: self sacrifice</li> <li>• Cultural and religious modesty</li> <li>• The infant’s rights</li> </ul>
<b>The Vulnerable Woman</b>	<ul style="list-style-type: none"> <li>• Exclusion</li> <li>• Discrimination and prejudice</li> <li>• Bureaucracy and ‘stiff upper lip’</li> <li>• Conflicting ideology/ cultural differences</li> <li>• The conventional as strange</li> </ul>
<b>Adaptation to a New Culture</b>	<ul style="list-style-type: none"> <li>• Adapting to care</li> <li>• Changes in gender roles</li> <li>• Adaptive behaviour</li> </ul>
<b>Dissonance Between Maternity Health Systems</b>	<ul style="list-style-type: none"> <li>• Midwife/doctor roles</li> <li>• Normality vs. medicalised care</li> <li>• Education</li> <li>• The strangeness of care</li> </ul>
<b>The Valuable Experience</b>	<ul style="list-style-type: none"> <li>• Valuing the midwife</li> <li>• Valuing the service</li> <li>• A positive experience</li> </ul>

## 6.2 Displacement and Reformation of the Self

This theme refers to the woman’s being displaced from the world she is used to and her existence in an alien world with her nuclear family. It includes the degree to which she settles into her new life and how this adjustment affected her inner-self. All the women in the study

were living as migrants in the UK, which they confirmed as an important aspect of their childbirth experience. The interviewees expanded at great length and in vivid detail on the differences between life in the UK and the life to which they were accustomed in their home countries. After adapting to life in an unfamiliar environment, the women affirmed the benefits of migration to the nuclear family.

To the women, migrating meant the moral transformation of their self-identities; they underwent a sense of profound social change. These changes had effects on the women as wives and as mothers, and on their relationships with the family. They described in detail the effect migration had on their sense of self, and importantly it featured in their experience of childbirth. The interviews revealed both positive and negative feelings about their immigrant status. The discussion of this theme will include consideration of the positive effect of migration on the woman when she is in the context only of her nuclear family, rather than her extended one. The vulnerable woman theme will explore how difficult and confusing the adaptation to a new life was for the migrant women during such a challenging time as pregnancy and childbirth.

This theme consists of four sub themes: the emerging dominance of the nuclear family over the extended family, the shift away from dependence, freedom from cultural constraints, and the achievement of peace of mind.

### ***6.2.1 The Emerging Dominance of the Nuclear Family Over the Extended Family: Self-Contained / Self-Worth***

This sub theme refers to how the social structures within the family changed as a result of migration and how, as a result, the woman's sense of self changed.

All the women in the study confirmed that their family relationships had changed as a result of their emigration to the UK. They described how the nuclear family became central to their world, as opposed to the traditional centrality of the extended family in Arabic countries.

All the women participating in the study were living in the UK with their husbands, far from their families and families-in-law. In Arabic countries, the nuclear family is protected and

governed by the extended family. As a result of migration, this typically Arabic hierarchical social organisation was disrupted and the extended family structure was replaced by one consisting of a nuclear family unit. Women, together with their husbands, had to experience life without the extended family and manage alone, without them. For the majority of participants, this more individual existence positively affected the couple's relationship. The women identified how they received greater attention from their husband and they developed a closer and more supportive relationship. When referring to their husbands, women used words such as 'more considerate', 'sympathised', 'attached', and 'compassionate' to describe the alteration in their husbands' feelings toward them. One woman said:

*When both of you are far from your families, you become so close to each other. He was like my friend and brother. He felt [empathised] with me and helped me. He knew that no one [else] was with me (Amina).*

Women described how emigration increased the unity between them and their husbands and highlighted their dependence on each other. As a result their behaviour towards each other changed, particularly for the men, who adopted a more active role in caring for the family. In contrast, women described how in Arabic countries there was no cultural imperative for a husband to adopt such a role as a wife's family would take responsibility for this. The nuclear family model gave the husband the opportunity to take care of his own family and enter his wife's world. He started to empathise with her in a different way than he did in his homeland:

*It brought us closer to each other. He sympathised with me more and became tender towards me. He felt a responsibility here, [because] in our culture, if the wife feels tired or sick, the husband will send her to the family's house to take care of her, and when she feels better she comes back to her husband's home. Here he took care of me and my son while I was tired (Fatima).*

The interviewees described how life in the UK was very different from life in Arabic countries. Social relationships between people are clearly defined in Arabic countries, and the nuclear family is integrated within the extended family. Members of an extended family are always together during their free time, holidays and on special occasions. There is no particular time for one family – they all share in everything. The man in Arabic countries has



to participate in social occasions related not only to the extended family but even to his neighbours, relatives and friends. Life in the UK releases the husband from these commitments and gives him more time to be with his wife and children and show his affection for them. In his country such affection is shared, between his nuclear and his extended family:

*In my country I did not see my husband much. He came home from work, sat with his family and at night went out with his friends. Here we are always with each other. It is true that he is busy studying, but when he is at home he is with me and my son (Fatima).*

Moreover, some women found life in the UK easier than in their home countries. In Arabic countries (except those in Gulf), the man has to do more than one job to cover the cost of living, and this does not give him enough time to be involved in his wife's care during childbirth:

*There everything is expensive and husbands have many worries. They work long hours to pay the bills. Here husbands are more relaxed. They come home at a more reasonable time. There are no family commitments at the weekend as there are in Egypt. This time is for the family and the baby. There, one day you have to go to your family-in-law and have lunch with them and the next day [the same with] your family. Couples are not close to each other. Here they are alone, they do everything together and they do not have any other people with them (Hiba).*

In Arabic countries, the most common family model is the extended family with a patriarchal structure. The man is considered as the head of the family and does no housework, which in a male-dominant hierarchical society would be seen as detracting from his status as a male. Even if he likes to do housework, cultural norms inhibit him. The presence of other females in the extended family excuses the man from performing housework; in fact, he would be afraid of being mocked if he did. Migrant husbands are compelled to help their wives, as there is no extended family, and they are brought face to face with the difficulties their wives face in taking care of the house and the children on their own during their pregnancies. As result of this, a more egalitarian husband-wife relationship develops:

*The Arabic man considers himself as the source of authority in the house. He is the man; he can't engage in household tasks. Here he participates in household tasks; he empathises with you more. In our country he refuses [to do] this, because he thinks his family will start talking about him if they find out (Zahra).*

The interviewees mentioned another benefit of living far from the extended families: their self-reliance, which replaced their dependence on the other females in their families. This dependence will now be explored.

### **6.2.2 Moving from Dependence: Self-Governing / Self-Reliance**

This subtheme refers to how an Arabic woman in her new world was forced to depend on herself more, because there is no one else she can rely on. And how her independence acquired her more self-reliance.

When she migrates, the Arab woman loses her family support. She has to perform on her own the tasks that were previously done with the help of others. This was highlighted by all participants, though the degree of previous dependence varied among the women. For example, servants were an essential part of family life in Saudi Arabia, but visa regulations make immigration to the UK difficult for servants. These women therefore had to do all household tasks themselves. They ultimately realized that they could live here without such help, and in the process they became completely self-sufficient:

*I feel I have become more independent. There are a lot of things that I would not do if I were in my country. For example, I would not do housework. I had a servant to take care of this. I would not go shopping for food; this would not be my responsibility. Here I take care of my son, while in my country my mother would help me (Kawther).*

This sense of independence is also partly related to the absence of the extended family. In general, adults in Arabic countries are attached to their families. Before their marriage they consult them in all matters, and afterwards they seek their advice about how to begin their lives as a couple. Following emigration, women described how they welcomed the chance to make decisions for themselves. Their emigration and separation from their mothers broadened their consciousness. They could make decisions on their own initiative without

their mother's guidance, and could accept responsibility for those decisions because they understood that they would be the one who would take the consequences of those decisions. They thus developed more mature attitudes, in contrast to their own countries, where the constant help offered by their families in making important decisions inhibited them from examining those issues in full. The women's gained more intellectual maturation which also affected their relationships with their husbands, who became aware of their newly acquired self-sufficiency:

*I became more responsible and no longer dependant on my mother....The advantage of living far away is that no one interferes in your life (Hiba).*

While the majority of women embraced the opportunity to make decisions and valued their independence of their families, they also remarked that this separation was a challenge. Arab women face challenges in living in the UK without the help of their extended families. These challenges developed women's personalities especially for those who are newly married. For these women, the experience of having to deal with several major transitional steps virtually simultaneously made them develop the strength to overcome these challenges. On the other hand, mothers understood that they needed the willpower to adjust to a new life without this change affecting their children. The challenges the women faced enhanced their individuality, giving them the strength to adapt to post-migration life:

*This affected me positively: it strengthened me and heightened my individuality. The marriage experience gave me willpower and let me be independent (Zahra).*

The nature of living as a migrant Arab Muslim woman in the UK required women to do things that would have been difficult or impossible in their own country, such as going out of the house unchaperoned. In some Arabic countries such as Saudi Arabia, this is strictly forbidden. Women are forbidden to drive a car and must always be accompanied by a male relative when going out. The use of public transport and interaction with people outside the home required considerable nerve. The interviewees became bolder in these respects after their arrival in this country:

*It makes me bolder. I can assimilate myself into life here.....My self-confidence has increased....I was happy that I could go out of the house alone. When I came back*

*from the USA to Saudi Arabia I suffered as if my wings had been broken. If you want to go outside you have to go with your husband, [but] here I can go by bus with total freedom (Fatima).*

Migration allowed these women to claim the responsibilities they valued and to attain a sense of self worth. The great benefit of migration was their necessary adoption of the nuclear family model that required a closer and more supportive relationship between husband and wife. Women valued experiencing this new family arrangement, valuing the contribution their husbands made. This included the husband's nontraditional role of supporting his wife during childbirth. The couples' freedom from the restrictions of traditional Arabic cultural beliefs also featured prominently in the women's experiences of childbirth.

### ***6.2.3 Freedom from Cultural Constraints: Self-Determination***

This subtheme refers to how the relieve from cultural constrains in the UK gave the woman the opportunity to live in the way she like not according to the wishes of her extended family.

In a communal society, family members pay each other attention as regards emotional bonding. Moreover, younger people seek consultation and guidance from elder people in the family. This pattern of life reflects how Arabic women are deprived from freedom and autonomy in the context of extended family. The most obvious example of freedom she got in her life in the UK is that she can live and raise her children as she wants, and not according to the wishes of her extended family. In their own countries, some of the participants lived in the same house as their families-in-law. It is a cultural norm for all family members to wake up, eat and sleep at the same time, and for the younger people to serve their elders. Migration to the UK frees the women from the burden of caring for their parents-in-law. The women interviewed for this study appreciated in general the freedom and liberation of their new lives, and their release from the restrictions of traditional rules in particular:

*When I came back from the USA I suffered in various ways. I found life difficult because of my commitments. When we were in the USA we could get up, go out, eat and sleep whenever we wanted. When I came back I had to follow the domestic routine, get up and eat at the same time as them. I had to wake up early to prepare breakfast for my parents-in-law and take it to them [because] they are old (Fatima).*

In the UK, the women encountered a country with different cultural and religious beliefs. To adapt to this new life they acted in ways that may have been considered strange or even unacceptable in their own countries. The interviewees appreciated the opportunities to explore new options. At the same time, they were aware of the criticisms they would be subjected to from their compatriots back home. Fatima gave an example of how her presence in a mixed class was forbidden in Saudi Arabia but was perfectly normal here:

*When I took English courses here I received much criticism from my family and family-in-law [about] how I would study in mixed classes of males and females. I said that it was okay for me. I would do it if I were convinced [that it was the right thing to do], but the old people would not understand this. It is something strange in our culture (Fatima).*

During childbirth, there were many things that their culture forbade the women to do. These restrictions irked the women in this study. In their new lives, they were released from their adherence to their mothers' and mother-in-laws' dictates, and felt able to make their own choices. They were living in a country with different cultural beliefs, and what was not allowed in Arabic countries was permitted here:

*[At home] we are not even allowed to walk long distances. I like to walk, and I travel a lot to London, so all these restrictions annoy me. I don't like anyone to restrict me, like "don't dance", but I like to dance, I don't like being treated this way. I did all the things they prevent me from doing, and nothing happened to me or to the baby; I delivered normally without any complications. This is the advantage of delivering here far away from your family (Amal).*

*They inhibited me with their advice. I was doing what they wanted [but] without really believing it. Here in the UK I can do what I want (Hiba).*

The women found life in the UK more organized and Arabs more practical here. In Arabic countries, the new mother can be visited at any time, as her family, who are constantly with her, will take care of well-wishers. Being alone in the UK restricts such visits, which means that planning is required:

*The situation here is different. I wrote the times and dates for visits on the website for Saudi women here in Leicester and [they] all followed the schedule. I chose the times my husband would not be at home and I slept well, [because] the times not open as in Saudi [Arabia]. The relations here are more organised and [relationships are] not as strong as in our country [because] everyone is busy here (Kawther).*

The other aspects of being a migrant woman that the interviewees stressed was their alienation from their familiar world, and how they lived in peace with their children and husbands without interference by others in their lives.

#### **6.2.4 Achieving Peace of Mind: Self-satisfaction**

This sub theme refers to how living as nuclear family in different country, frees the women from interference of extended family in their lives.

The women described how living in the UK alone with their husbands gave them the chance to arrange their lives how they wanted. Couples were still subjected to some interference from the extended family, though to a lesser degree than if they had been physically present.

In Arab society, pregnancy is believed to be an immediate and natural result of marriage: the woman fulfils her social role by becoming a mother and completing the family unit of “a father, a mother and children”. This ensures the continuation of the ancestral line. Any delay in pregnancy worries the extended family and causes them to investigate the causes. The effect of such interference is lessened by distance:

*I was so happy because I got pregnant six months after getting married. In our culture people believe that the woman has to get pregnant once she is married. They made me worried because of their questions like “Why have you not become pregnant until now?” They told me to see the obstetrician for treatment. This was okay for me and my husband.... My mother-in-law, my mother and my relatives all put me under pressure (Hiba).*

Becoming pregnant in another country freed women from such annoying comments, especially those concerning the deterioration of their figures. They needed support, not criticism of their appearance. In women's new world no one interfered in personal issues, because families were not close to each other as they are in their own countries, they are only friends not relative.

*Here there are no relatives to see you during pregnancy and comment on your shape, or that you have put on too much weight, and who start guessing from the shape of your abdomen whether your baby is a boy or a girl. No one sees you during pregnancy and after labour, and this is better (Kawther).*

In describing their life in the UK, women highlighted it was less problematic than at home in a number of ways. Participants identified that husband and wife treated each other differently. Marital problems decreased without the intervention of the extended family and as the couples' understanding of each other increased:

*I thought life here was wonderful. There are no problems created by other people, no one will interfere with your life. You live quietly, peacefully.... Here it is better: there is no interference. There, there is always interference in the woman's life: the husband's family talks to him and problems start. Here we depend on ourselves; if there is a problem, we solve it alone. Any small problem becomes more complicated by the family's interference. (Amina).*

Women with children found their lives to be calmer, again linked to the lack of interference from family members. Women described how in Arabic culture respect and esteem increase with age, which is equated with experience. It is expected therefore that one consults older members of the family about raising children. In contrast, migration to the UK offered women the freedom to make their own decisions about their children.

*Here I am more settled in my married life. I can bring up my son in the way that I want. I feel that we are a family and that the family surrounds me, and this thought comforts me. There is no interference in my life. I live as I want to without worrying about the problems that can arise from [tensions between] the family and the relatives (Fatima).*

After the women had settled into their lives, they rebuilding new personalities because they understood the challenges they faced and tried to make the transition to their new life successful. Naturally, as all the women in the study were pregnant, they had to obtain access to the maternity services in their adopted country. They compared the whole childbirth process with what it would have been in their homelands, with their extended families. They provided a vivid picture of the cultural and religious beliefs they practice there. They really missed the environment surrounding them in childbirth; this will be discussed in the following theme.

### **6.3 By the Grace of God**

This theme refers to how childbirth is perceived as a gift from God in Arab Muslim communities, and the importance of thanking Him for this gift.

*This was my second pregnancy; my first daughter was seven months old. I was annoyed and afraid that I was pregnant, especially as I was far from my family, but I have to say thanks to God for everything. I sat and thought, and after that I agreed that God would choose the best for us. As the prophet Mohammed said, “if you see the secret you will choose the reality” (Amal).*

*Here I was crying without any reason. I didn’t know why I was crying. Perhaps it was because I was depressed. I was always asking God for forgiveness because he let me get pregnant and I had to thank him for the grace not to cry (Hiba).*

Arabs believe that pregnancy is a gift from God, for which they give thanks by taking care of mothers and their children. They show their gratitude in many ways. The sub-themes below explain the pervading impact of religion on traditional Arabic practices concerning childbirth. These sub-themes are those of safeguarding the woman, the goddess mother, dealing with the boon, birth as a rite of passage, the price of mothering, cultural and religious modesty and the infant’s rights.



### **6.3.1 Safeguarding the Woman**

Arab Muslims see a pregnant woman as responsible for two spirits or ‘souls’ (hers and her unborn child’s). The latter is a loan that God will ask her for at doomsday. She must take care of herself in order to protect this loan. Once the pregnancy is confirmed, the woman receives extensive attention from the females around her – usually from her mother and mother-in-law. They support her physically and psychologically in order to safeguard her unborn child. To this effect they advocate eating healthy food with increased amounts of protein. In contrast to Western culture, Arabs consider pregnancy as an abnormal condition, and so the woman must have enough rest, especially in the first three months, so as to avoid a miscarriage, as well as eating healthily.

*I concentrate on eating healthy foods and increasing the amount of fruit, vegetables and protein. I decrease sugar intake during pregnancy. As Arabs always say, the pregnant women must eat for two (herself and the baby). If the woman wants to eat anything, the husband is responsible for bringing it for her, or the baby will come with nevus in his body.... During her pregnancy the woman must not lift anything heavy, and she must move around less in the first three months. She must not travel, nor sit in a car for long periods or burden her body. All of these may cause a miscarriage (Amal).*

There is a clear concern here for the correct diet during pregnancy and postpartum. Arabs believe in a balanced “hot” and “cold” diet to achieve a body balance. This model classifies both the body at any given time and a given type of food as hot or cold, and requires an individual to partake primarily of the category of food that is the opposite of that of their body at that time. In Arabic countries pregnant women are considered “hot”, and must avoid that category of food so as to sustain a balanced temperature and thereby prevent a miscarriage.

*When they know you are pregnant they tell you to stop drinking fenugreek and cinnamon, [because] they are hot and may cause a miscarriage (Hadeel).*

*They stop us drinking hot things like cinnamon and ginger because they will cause a miscarriage or early delivery (Kawther).*

*...the pregnant woman must eat cold foods like watermelon (Zahra).*

From my own postpartum experience in an Arab country, the women there told me that I was at a dangerous stage. There was an adage which they repeated many times to me: “the grave of the confined woman remains open for 40 days”. This means that the woman’s body is weak, and anything can affect her during this period. She must take care of her rest, nutrition, temperature and mental state. They were always telling me that “your bones are still open”, which meant that my bones were out of joint and my body was in the “cold” category after I had given birth, so that any exposure to cold would penetrate my bones and adversely affect my body. I had to keep my body warm and take “hot” food to regain balance. A woman’s consumption of “cold” foods will affect her health and cause her to become sick. The effect of these imbalances would continue in later life, resulting in complications. As the woman is in a “cold” state after giving birth, she must keep herself warm, wear warm clothes and avoid taking full baths, especially in the first week:

*She must drink soup, fresh juice and milk instead of water, and eat healthy food. She must not drink any cold liquid because it will affect her weak body. Also, she must wear warm clothes and drink hot fluids because her bones are still open (Kawther’s mother).*

*They concentrate on eating dates, drinking fenugreek daily and on ginger; I drank this for three months....The woman must not drink cold drinks or eat readymade food....We say that the woman’s bones will be “opened” – that is, disjointed. The new mother must always keep herself warm and her breast must not be exposed. For myself, I did not take a shower the first week. All doctors encourage you to take a shower but I say this is wrong. I am always careful to clean my breasts and my genital area, but I will not wet my hair and my [whole] body. In the first week, I always tried to be warm. In my first delivery, I took many showers in the first week and I became sick. The woman must always wear cotton and cover her whole body (Rahma).*

The woman must be relaxed and cheerful during her pregnancy. Arabs avoid giving pregnant women bad news; they oblige the husband to preserve her mental state and avoid stressing

her because they believe that everything affects the baby. She is also required often to read, and to have read to her, the Qur'an<sup>2</sup> as this will be transmitted to the baby and subsequently affect the development of his or her personality.

*They advise her to hear the Qur'an continuously, not to shout or stress herself and to try to keep herself relaxed. All of these things will affect the baby (Fatima).*

*My mother said to avoid any trouble between you and your husband and don't shout, or it will affect the baby's personality.... try always to hear the Qur'an ... This will all be transmitted to the baby (Kawther).*

*I try to keep in a happy frame of mind. I believe that everything I feel will be transmitted to the baby. From the moment I became pregnant I tried to keep relaxed so as not to transmit any negative feelings to the baby (Rahma).*

According to the participants there are a number of postpartum practices beneficial to the woman's health. After birth, they are concerned with healthy food and rest for the new mother. By these means she can return to her pre-pregnancy state and replace the amount of blood she has lost during delivery. On other hand, they give foods that increase the amount of breast milk. For the 40-day postpartum period women receive good care that focuses on high-quality food and help with the daily routine of home and children:

*I concentrated on green vegetables and dairy products so as to increase my milk. In our country they fry eggs and dates with butter for breakfast. They concentrate on fatty food in the postpartum period. They cook a lot of liver as it compensates for the blood lost... They cook crauyia with rice ground and topped with nuts, which is useful for breastfeeding. The most important thing for the new mother is to eat well and rest (Amal).*

*After delivery we concentrate on the quality of food, [and specifically on] not eating rice, carbohydrates or spicy food and on drinking lots of water because it will dilute*

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<sup>2</sup> Qur'an: Allah's final revelation to Man ,and the primary source of Islamic Law. Previous revelations have included The Psalms of David, The Torah of Moses and The Gospel of Jesus (Sheikh and Gatrad 2008, p137).

*the milk. She must stay in bed for the first ten days, and then she can move around the house if she feels strong (Kawther's mother).*

*In my country they concentrate on a new mother's feelings, her rest and her nutrition. Every day they cook soup with chicken and meat and hot drinks like cinnamon to clean the uterus and carauia to increase her breast milk (Hadeel).*

*Instead of the special food for the new mother, and well-wishers who come to visit her, like cinnamon which causes mild contractions and helps the woman to be purged early, and "caroya" to increase breast milk. In the first week the woman does not move from her bed, and [even] after that they keep sending food and cleaning the house for you for 40 days. In our culture the woman feels [a great deal of] concern for her and much emotional support (Rahma).*

Women in Arab countries receive much attention during their pregnancies regarding their diet, rest and the maintenance of their positive outlook. This attention is continued intensively after childbirth. There is a celebration of the birth as a happy event. Included in this celebration is preparing the childbearing woman for the occasion, revering her role as a mother. These rituals will be discussed in the goddess mother sub-theme that follows.

### **6.3.2 The 'Goddess' Mother**

An Arabic adage says of new mothers: "a bride delivered baby bride or groom". The status of an Arab woman increases following childbirth in recognition of their role in maintaining family lineage. In the postpartum period a woman's achievement in giving birth is celebrated by all her female friends and relatives who come to congratulate her. She must prepare herself in advance to look beautiful at this time:

*Before delivery, I bought new clothes for me and the baby, and I dyed my hair (Amina).*

*In Jordan the new mother is like a bride: If she has well-wishers [visiting], she must put on makeup, comb her hair and dry it with a hair drier. If the woman likes to dye or cut her hair she must do it before delivery to look beautiful afterwards. She must*

*take care of her looks [because] they will give her a lift and boost her psychological state. We take makeup and hair driers to hospital to maintain her appearance there. She must also buy new pyjamas and new camisoles to wear when she has well-wishers (Rahma).*

*Generally the new mother wears new pyjamas in bright colours. She will lie in bed and the women will sit with her in her bedroom (Amal).*

Moreover, some Arab practices help the woman's figure return to her pre-pregnant, attractive state. This is very important, because it keeps the woman beautiful in her husband's eyes:

*We heat sand and wrap it in a bed sheet and put it on the woman's abdomen, [because] it helps in cleansing her from blood and preventing abdominal flabbiness (Amina).*

*She must take black honey for forty days. It will close the woman's vagina. One of our prophets, Mohammed's friend, came and told him he couldn't touch his wife after seeing her deliver. The prophet brought black honey and put his finger inside and when he removed his finger the honey closed the aperture. He said that the woman, like the honey, would return to her pre-delivery state, [and] because of that, with honey you return to a virginal state. (Kawther's mother).*

*Kawther added:*

*She tied my abdomen after delivery and she let me lie on my abdomen over a [hot, wrapped] brick. I lay every day for one hour so that the heat would penetrate my body and I would be warm, as I was before the pregnancy. It is very useful. I started wearing all my old clothes forty days after delivery. Even my size changed from 14 to 12, and thank God my weight increased by only two kilograms from before the pregnancy. However, the idea is not the weight but the shape. Now I have lost a lot of flabbiness (Kawther).*

Women are esteemed in Arab society after their deliveries for their role in continuing the family line. Arabs also appreciate the unborn baby, which they consider as a precious gift from Allah. In this sub theme, the word "boon" is used instead of "baby", both because it is

more spiritual and because it encapsulates the main theme of “by the grace of God” with all its sub themes that explore the religious influence on Arab Muslim childbirth practices. The data revealed three aspects of the Arabic perception of the boon. The women discussed how they ensured the baby remained safe in the womb, the issue of the baby’s gender and views on contraception and birth spacing .

### **6.3.3 The Boon<sup>3</sup> (Conservation, Acceptance, Systematisation)**

Muslims believe that life and death comes at the hand of God, not by that of humans. They also believe in predestination, and they accept their destiny without demur. Their role is simply to thank Allah for everything and trust in him; he will choose what is best for them. This is one of the seven Islamic articles: to believe that Allah created everything and knows the fate of all things. What is good and evil has been decreed by God. Specifically, in relation to childbirth, parents have no right to electively terminate a pregnancy; it is forbidden both culturally and religiously. As pregnancy is considered a gift from Allah, the woman must preserve it and be content with what God has ordained for her. Women know beforehand that they cannot abort their babies. Some Arab Muslim women do not like to have antenatal screening tests for this reason, for fear of placing their baby in jeopardy and abortion would not be considered, even if a positive result occurred:

*Once she told me that I had to do test and they would take a sample from the amniotic fluid. I refused this test. I had some experience of that during my first pregnancy. She wrote the name of that test on a piece of paper and told me, “ Ask your husband.” He refused also....Even if I knew the baby was abnormal, I would not abort him....[b]ecause we are Muslims and our God does not approve of this. It is a religious matter; it is forbidden in our religion. The test was useless; I would only suffer pain because of it. If the baby were abnormal, I would accept what God wants for me. This is my destiny and I believe that, so I couldn’t do the test (Amina).*

*She asked me to do some tests like Downs syndrome but I refused. She had some idea that I would refuse as a Muslim because she asked me if I wanted to do that test. I couldn’t do this test because it is forbidden in our religion to do an abortion. (Zahra).*

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<sup>3</sup> Boon: something beneficial; blessing. Derived from Old Norse bon, prayer.

All women who participated in the study referred to their babies the same way, irrespective of gender. In Arab Muslim societies, however, there is a distinction made between the sexes, with a preference shown toward sons. This unhealthy view is a cultural one, pertaining only to these societies. It has nothing to do with religion: in the Qur'an, men and women are addressed on equal terms. In fact, many verses reject the distinction between male and female, suggesting that both play an equal role in society and have the same rights and responsibilities. From a religious perspective, individuals should thank the God for boys and girls.

I explored this issue with the women who participated in the study. Some women asserted that they wanted both boys and girls:

*I was happy and felt normal. I didn't mind if it was a boy or a girl – both were good. Maybe at first I said that a boy would be better for variety (I had already a girl), then I thought that two girls would be better because they would be friends when they grew up, so I was happy<sup>(Amal)</sup>.*

*When I found out that I was pregnant I sensed that it was a boy. I wanted a girl this time because I [already] had a boy, but when they told me it was a boy I thanked God and prayed [for it] to be in good health (Fatima).*

One interviewee said that she wanted a baby boy to please her husband and his family, not for her own preference:

*In Arab society they prefer boys and have different views about girls. I was happy [that I had] delivered a baby boy, not because I don't like girls, but because my husband and his family like boys more. It is mentioned in our Qur'an that "if you [are] informed of a baby girl your face becomes blackened and anguished". On religious grounds, it is not acceptable to be angry if you get a baby girl (Hadeel).*

Some of the women believed that only boys enlarged the family and continued the family its line, because boys keep the family name and pass that name on to their sons, which preserves the honour of the family:

*I was so happy, my husband wanted a boy. He is an only child, with no sisters or brothers and he wanted to enlarge his family. I was happy because the wish of my husband was fulfilled (Kawther).*

Some Arab societies still view the birth of a girl negatively. Fortunately, through education and increased religious awareness, these views are changing:

*There is no equality at all: they love boys more. Boys are better than girls there. It was more like that before, but now thank God they have become more educated and sensible... They must believe that everything comes from God: he will give and take. Secondly, the man is the one who decides the baby's sex, but they put all the responsibility [for this] on the woman. They say that she causes girls to be born (Amina).*

One woman gave us a good description of the view of some Arab Muslim families about girls, and why some prefer boys:

*... In my family everyone loves girls, including my father and grandfather. Actually, there is a partiality for girls. My father always says that she is like a guest: we have to take care of her and pamper her. She will eventually leave us to go to her husband's house but a boy will stay and bring a new member to our family. In other families they prefer boys more (Amal).*

The women explained why some families preferred boys to girls:

*They definitely prefer boys, and their happiness [when they find out that they are to have a boy] is twice what it is for a girl. This is because they think that the female is a burden from the time she is born until her death (Fatima).*

*... A boy will support his family, his mother, father and sisters more [than a girl will]. He will be responsible for them all. This is our Muslim law: it obligates him financially and morally. But the girl will marry and there is no obligation on her side towards her [own] family. On the contrary, she needs help all her life. In our society*



*she is weak and needs support, but the boy is the person on whom everything will depend (Amal).*

The last issue the women discussed was that of the spacing between children. The term “contraception” is not used because in Islam couples are not allowed to prevent pregnancies, only to space their occurrence. Both religious belief and socio-cultural traditions shape this view of contraception.

Muslims believe that it is their duty to fill the whole earth. The prophet Mohammed ordered Muslims to increase their numbers, so practices that limit the number of births are prohibited. Muslim societies view the issue of contraceptives in two ways: some prohibit it, while for the majority they are officially allowed but discouraged. As the Qur’an stipulates breastfeeding for two years, Muslim find it best to keep this period of time between pregnancies:

*In general Arabs don’t like to have more than about two years between their children... I wanted ... to do a Master’s degree. I will submit my paper in August and if it is accepted I will delay my pregnancy, but if not I will only wait one year for the next pregnancy (Hiba).*

*It depends on the woman’s health and her circumstances. I think two years between each baby is enough? More than this will mean that there is too much difference in age, and they will not be happy together. This is our culture. My mother delivered us with two years between. Me and my brother are close to each other and happy. I feel I have to be like my mother (Amal).*

*At the six-week check up I met the GP and asked him for a [contraceptive] tablet. In general the Arab prefers there to be two years between each baby (Amina).*

Muslims have recently begun to favour a longer period between pregnancies because of economic difficulties and the inconvenience of raising children:

*... now with difficult economical circumstances most people have bigger gaps between deliveries and don’t like to have more children like before (Amal).*

The cultural and religious importance of having children has generally limited the use of modern contraceptive methods in Arab Muslim societies. Natural methods are acceptable, however. It is noteworthy that participants in this study used such natural methods of birth spacing, such as the maintenance of safe periods and coitus interruptus. This is more acceptable both culturally and on religious grounds. Three women became pregnant within four months of their deliveries:

*I did not ask the midwife and she did not explain it to me. My husband does not like to use these artificial methods. We do it the natural way (Amal).*

*People are now more aware of birth spacing, especially working women, and many use natural methods (Rahma).*

Delivery itself must be explored in the context of religion. It is perceived that a childbearing woman is closer to God while feeling the pain of contractions and as a result, she can be confident that her prayers will be answered. This is referred to as closer to God.

#### **6.3.4 Closer to God: Self-Purification**

Muslims view the woman as being born again after delivery. The pain of contractions is mentioned by the Prophet Mohammed; he said if we were to serve our mothers for all our lives, this would not equal the pain of one of the contractions they suffered when they gave birth to us. Muslims view this time in an intensely religious light, because one spirit is released from another with the help of Allah, who eases the delivery and grants the baby and the mother a new life. The woman is cleansed of all her sins. Their realisation of the enormous significance of that moment is shown by reading the Qur'an and praying with women being confident of a response to their prayers. In my work experience I have often observed Arab gynaecologists and midwives encourage women by reading the Qur'an and praying for her, or reminding her to do it. It is also an Arab custom that people with problems ask pregnant women to pray for them during her labour:

*During delivery I was praying. I remembered my sister who is dumb, some people I know are sick. I prayed to my God to cure them all. I prayed for my friend who is infertile to have a baby. I mentioned her name and her mother's name. I prayed for*

*myself, that God would ease my delivery and [that I would] have a healthy baby, for my husband to finish his PhD, and that we would return safely to our country.... When the woman suffers from labour pains during delivery, the doors of the sky will be opened, and God will respond to her prayer. Because of this, it is recommended that you pray during delivery, [because] nothing will hide your prayer. During labour you will be in a high spiritual state, [so that] when you pray you feel that you are in God hands and in His care, with all the angels around you (Kawther).*

*I was crying.... I cried from the praying and I asked God in Heaven .... When the woman prays during her labour, all her sins will be erased, she will get a martyr's reward, and all her prayers will be accepted by God (Amal).*

*In labour the woman must be quiet and positive. She must pray, read the Qur'an and be sure that God is with her. At the moment that the head comes out, all prayers are accepted, so I prayed in a high voice (Rahma).*

Arab women well understand the blessings God has given them. They perceive mothering in a moral light, as a vocation. The Arab woman sacrifices herself for her children. The interviewees told of their feelings toward their children in the following sub-theme.

### **6.3.5 The Price of Mothering: Self- Sacrifice**

Traditionally, Arabic mothers live for their children. They tend to forget about their own interests and put their children first. This was evident when pregnant women who were already mothers expressed anxiety about who would take care of their children when they were in hospital delivering:

*I was worried that my family would not be beside me when I delivered. Who would take care of my son when I was in hospital, and who would take care of me and the baby after delivery?(Kawther).*

They only went to hospital a few hours before delivering, tolerating labour pains at home in order to stay as long as possible with their children, and during the labour itself they were thinking only of them. In addition, they pressed to be discharged as soon as possible:

*I did not go directly to the hospital. I did not like to go early because of my daughter. My husband told me to go to the hospital but I did not agree. When he insisted....I sent my daughter to my neighbour. I lay beside her until she slept, and then I went to the hospital...During contractions, I was thinking of my elder daughter. After delivery, I was worried about the baby. They were asking about me. I did not even answer. I only asked about the baby. I want to be sure about her. The most important thing in my life is my daughters. I do not care about myself.... Three hours after delivery I went home. My concern was my elder daughter (Amal).*

Many of the Arabic Muslim women concentrated on breastfeeding their children in spite of all the difficulties they faced:

*It is necessary for the baby to take his mother's breast for the first three days even if it is difficult and painful because of colostrum. This yellow milk is full of immunity boosters and the woman must bear the pain (Amina).*

As discussed earlier, Arabic Muslims are concerned about a new mother's appearance after delivery. They consider that her main task is to breastfeed the baby, and they encourage her in this. They introduce breastfeeding on breast shape; it is a gift from Allah and they thank Him by breastfeeding the baby:

*The most beautiful thing after delivery is breastfeeding; it is painful for the first week. I consider it as an essential feeling of motherhood. I am trying to breastfeed as long as I can. In Jordan everyone encourages breastfeeding. In our culture they are not concerned with how the body looks. The woman's breast must be raised. They believe that the woman, her children and her family has priority, so she is not obsessed with how her breasts will look after breastfeeding as, Western women [are]. In contrast the woman likes to breastfeed as it is part of her motherhood. She considers it as a normal sacrifice to the grace of motherhood, and that it is her duty. Our religion also advises us to breastfeed for two years, [so the] two issues of culture and religion come together. Women mostly breastfeed (Rahma).*

Arabic people blame the woman if she does not breastfeed for any reason. According to my field notes Hiba informed me before starting recording of the postnatal interview that, when she went back to Egypt six weeks after delivery, she felt guilty because the people there considered that she was not doing her job when she did not breastfeed. Amal also felt the same with her first baby:

*My first baby was always crying and wanting my breast but there was no milk. Because of that I started giving her artificial milk.... But I still rebuked myself because I did not breastfeed her. That is why I am now so happy that I can breastfeed my baby. This milk is a gift from God. We have to thank our God for this grace [because he gives us the means of] breastfeeding our babies (Amal).*

Both Arabic culture and Islam inspire breastfeeding. This attitude obliges the woman to breastfeed for her to be considered as a good mother:

*Breastfeeding is mentioned in the Qur'an and it is recommended to breastfeed for two years. Culturally everyone encourages breastfeeding, and this is [regarded as the mother's] duty. After the delivery, the first thing everyone asks is "Do you breastfeed the baby?" (Kawther).*

As revealed from the data, breastfeeding is an important part of childbearing among Arab Muslim women. Women are encouraged and viewed positively if they do so. The women also discussed breastfeeding in the context of privacy. In the next sub-theme, two aspects of this issue will be discussed: the doctor's gender, and specifically the preference for female rather than male doctor, and breastfeeding.

### **6.3.6 Cultural and Religious Modesty**

A woman's purdah and her modesty is a central issue in Islam, which considers the woman as a jewel, needing to be protected from prying eyes. Women are regarded as inherently attractive, which leads to serious problems. The religion therefore demands that women cover themselves except for their faces and hands. Childbirth is an important event for Arabs, and women comply with Islamic precepts in order to express their gratitude to Allah for becoming a mother. However Islam does allow women to expose themselves in certain

situations, but the women interviewed found it difficult to do this because of their accustomed prudence:

*Two nurses came and assisted me to go to the bathroom, and asked me if I needed help to take a shower. I said, “No, I can have one alone”. I felt shy about exposing my body. I have grown up like this. It is a cultural and religious issue. In our religion, if there is a need, it is allowed [to expose oneself]. Because of this I did not object to exposing my body in the operation, but it did make me nervous, while now I could have a shower alone (Amina).*

The religion does allow women to breastfeed in the presence of other women. Culturally, the woman only needs to cover her breast. In this situation, the women in this study had different practices: some did this while others breastfed their babies in a separate room alone:

*If I am visiting [someone or somewhere], men and women aren’t allowed to sit together for religious reasons. I don’t reject breastfeeding while sitting with women. I only cover my breast so that they do not see it (Amal).*

*Breastfeeding is private, If she sits with males and females she must move away and sit in another room to breastfeed, while if she sits only with women she can breastfeed but [she must] cover her breast. She has to take care not to be so tactless as to expose her breast. It is not a religious matter, because our religion allows us to show our breasts in front of other women, but we do this because of custom and politeness (Rahma).*

The situation with Kawther was a little different. She refused the help of nurses in breastfeeding because her shyness prevented her exposing her breast:

*When they moved me to my room one nurse asked me, “Do you know how to handle and breastfeed him?” and I replied, “Yes”, because I didn’t want to expose my breast in front of her .... I didn’t want to breastfeed in front of anyone. It is not a religious issue; it’s just that I feel shy. I don’t even breastfeed my baby in front of my mother. I like to be with my baby alone when breastfeeding, [so] when I have visitors I excuse myself and go up[stairs] to breastfeed him (Kawther).*

Privacy was a theme to which all women referred. They were confused during antenatal examination, labour itself and in the postpartum period:

*But during scans they do not cover me, neither when they measure the length of my abdomen .... During delivery they covered me as they do in Jordan. This is an important issue for me....I was only wearing a gown. During delivery I was really worried that if any one entered the room I was exposed from the waist down. In Jordan they cover all your legs and abdomen. Only the genital area is exposed, but when she sutured me she covered me like they do in Jordan.... When I wanted to go to the toilet it was near my room. I asked the nurse to see if there were any males around. I know that no one will look at me [when I am] in this situation, but for religious reasons I have to cover my head and body, and they understood (Rahma).*

There are many customs concerning birth, such as the Adhan, Tahneek, circumcision, shaving the hair, choosing a name and Aqiqah that are recommended in Islamic teaching. These practices are not considered to be parental preferences but the infant's rights. The following sub-theme explored this area.

### **6.3.7 Infant's Rights**

Islamic tenets clearly assert the infant's rights over those of its parents. These rights become effective before conception and continue through pregnancy and childbirth into its early life. They must be well respected by parents. The baby must be legitimately born to a couple married according to an Islamic contract, and has the right to know its parentage. Islam advises the woman to start teaching the baby while it is still in the foetal stage:

*The most important thing is to read Qur'an everyday because the baby will hear the voice of the mother reading it, and after delivery it will always like to hear the Qur'an and will be quiet after delivery if it hears it. Also, when they grow up it will help them to be pious (Amal).*

After birth, the first word the newborn should hear is “Allah”. The father whispers the Adhan<sup>4</sup> into the infant’s right ear and the Iqamah<sup>5</sup> into the left. This ceremony takes a few minutes and should be performed as soon as possible after birth:

*In the hospital, after they cut the umbilical cord, my husband whispered the Adhan (call to prayer) into the baby’s ears (Kawther).*

*When I delivered the baby, my husband immediately whispered the Adhan (the call to prayer) into his ear, so the first thing the baby heard is a call to prayer (Rahma).*

Another newborn right is the Tahneek. One of the parents will gently rub the infant’s upper palate with a small soft piece of date:

*I kept dates in my bag, and in the labour room my husband scrubbed the baby’s gums with it and whispered the Adhan in his ears, without the midwife seeing us. We didn’t want her to start asking us why we did this, [and saying that] it wasn’t allowed (Fatima).*

The next right is choosing the baby’s name. This should have a positive meaning in Arabic. The following quote demonstrates the rules by which Arabs choose the name:

*Usually we like to assign the name on a religious basis. We take the names of famous characters in our religion, and the ones who are important in history. For example we call this baby Maryam (Mary), which is the name of our Lady. We know her story from the Qur’an. She was chaste and delivered without any man touching her. My first daughter was named Asia, the name of Pharaoh’s wife, [because] she patiently bore with her husband. All these characters’ stories are mentioned in the Qur’an (Amal).*

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<sup>4</sup> Adhan: the call to prayer. Within this call are incorporated the basic tenets of Islam: the belief that Allah alone is worthy of worship and that Muhammad is His messenger. The call concludes with the reminder that true felicity is dependent on the realisation of this basic truth (Sheikh and Gatrada 2008, p135).

<sup>5</sup> Iqamah: the second call to prayer immediately preceding the prayer itself (Sheikh and Gatrada 2008 P136)



*If you know the sex of the baby beforehand and choose the name immediately after the delivery, you give him his name. The name must have a beautiful meaning in Arabic. It is better for it to be like one of the prophets' names. Mostly, the first male baby in the family takes the name of the grandfather to inherit the name and keep it in the family (Kawther).*

Another Muslim practice after birth is the circumcision of male babies. It is preferable that this be done in the first month because the baby's nervous system is still immature and it is therefore relatively insensitive to pain. In Arab countries it is a routine procedure before discharging the mother from the hospital. The male should be circumcised before he reaches puberty for reasons of hygiene, because clothes stained with urine nullify prayer:

*When we were in Jordan....I, my husband and my father-in-law went to the doctor's clinic and circumcised the baby. When we returned home we bought sweets and distributed them in my father-in-law's house (Hadeel).*

*When I was discharged from the hospital I wanted to circumcise the baby. I asked one Muslim friend and she give me the address of a private clinic. I went there with my husband. Thank God everything was fine and the baby recovered quickly (Kawther).*

Female circumcision ("female genital tract mutilation") is not mandated by Islamic law as is its male counterpart. It is illegal in many Arab countries, but is still performed in some Arabic regions. None of the women who participated in this study practised female circumcision, a custom they viewed in a negative light:

*In Syria there is nothing likes this. It may exist in Egyptian villages. I'm starting to hear a lot about it now on TV. Clerics have given the legal opinion that it is taboo because it endangers the female. It is a custom; it has nothing to do with religion. They do it to decrease the woman's desire, but it has no basis in religion (Amal).*

*In our country this thing is not allowed, and has not been done before or now. I heard that it is done in Egypt and Somalia. We are concerned for the girl, and no one is allowed to touch the genital area. It is a very sensitive area. As you know, the girl*

*must be a virgin before she marries. It is forbidden to do anything to this area [i.e. the genitalia] (Amina).*

*It happened a long time ago in Egypt, and it may still be practised in rural areas. It is not now permitted in hospitals or clinics. The government will punish doctors who perform it. The old women in the villages still perform it (Hiba).*

*I was surprised when I heard about it, [because] in Syrian countries we never heard about it. I grew up in Saudi Arabia and have not heard of it; in Jordan they not do it. I feel that the way they do it, the procedure itself, is inhuman and unjust and will traumatise the girl. Some girls have died during the operation. It is not a religious duty and because it will cause injury, they did not used to do it. It deprives the woman of sexual enjoyment and makes her feel that she has been deprived of her natural rights. I am against this practice (Rahma).*

Another way to exhibit gratitude to Allah is by shaving the infant's hair. Traditionally it is done on the seventh day. The hair is weighed and the equivalent weight of gold or silver is distributed as money to poor people, according to the Qur'ans injunction to continually practice charity. In this study only one woman shaved the baby's hair. The majority of parents were afraid to injure the baby, as only experts carry out this procedure in Arab countries:

*I also shaved the baby's head and weighed the hair and distributed the weight in gold, and I circumcised the baby (Kawther)*

*We do not shave his head because we are afraid to injure him, and here they will think that we have abused him and we will be in trouble (Fatima).*

The last of the baby's rights is to show one's gratitude to Allah. Muslim parents must demonstrate this obligation by sacrificing a sheep for every newborn child and feeding the

relatives and friends (this is known as Aqiqa<sup>6</sup>). In Islam, feeding people irrespective of their religion is considered as charity, and more merit is gained if people in need are fed:

*I did Aqiqa. We slaughtered a sheep, cooked it and invited our neighbours and friends to celebrate. Moreover I get requital from God because I fed people (Amal).*

Muslims usually perform Aqiqa on the seventh day, but migrants who have no help from their families can postpone it until the woman is physically fit and has enough money for it. In fact, it can be performed at any stage during the child's lifetime:

*Four weeks after delivering I also did the Aqiqa. We cooked a meal and invited our friends for lunch. In our country we do the Aqiqa on the seventh day after delivery, but because I am here alone I waited until I was fit (Amina).*

Ideally the Aqiqa must be done at the same location as the mother and baby, but for migrants it can be done in their homeland (i.e. in their absence) because more people are in need there:

*We do Aqiqa for the baby, but in Saudi Arabia my family slaughtered two sheep and distributed [the meat] to poor people and my mother-in-law did the same. We should do the Aqiqa here and cook and invite all our friends, but I was tired and my mother was busy with me and the baby, so they did it in Saudi [Arabia] (Kawther).*

Women have to contend with a number of issues during their experience of childbirth in the UK. I have explained how they were transformed in many respects as a result of their adaptation to the life in the UK, and have outlined Arab Muslim practices during childbirth. I will now show the difficulties the women faced during their childbirth here, when they are far from their families, dealing with an unfamiliar health system.

## 6.4 The Vulnerable Woman

The challenges faced the women during their experience of childbirth in the UK have been increased by their awareness of the cultural aspects of childbirth in their home countries. Life

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<sup>6</sup> Aqiqa: The celebratory sacrifice of an animal upon the birth of a child. The meat is distributed between family members, friends and the poor (Sheikh and Gatrad 2008, p135).

in the UK was an environment alien to the women in terms of religion, culture, language, beliefs and social structure which presented many difficulties when they try to access maternity services in the UK. These difficulties have been interpreted in the following sub-themes, which are discussed in terms exclusion; discrimination and prejudice; bureaucracy and “stiff upper lip”; conflicting ideology, and the conventional as strange.

#### **6.4.1 Exclusion**

The exclusion sub-theme refers to the woman’s isolation on migration to the UK within the new country. There were many types of isolation suffered by the women in this study, both before and during their childbirth experience, one of which was social isolation. Participants explained how they were lonely, especially after losing their social support from their families. Another type was language isolation, of which communication problems formed a large part.

Childbirth in Arab countries is a collective issue. Women generally receive help and support from other women in the family. In the UK, on the other hand, women reported that the experience of childbirth was a burden for both the woman and her husband. The women described their feelings of helplessness and alienation when recalling their initial attempts to settle here. They felt isolated and in need of someone to whom they could express their feelings and who would support them. In some cases they could not talk to their husbands because they were the source of the problem, neither could they approach other Arab Muslim women for fear of gossip. The language barrier prevented them speaking with British women:

*My family is far from me; every day I was crying. I felt lonely: if I died, no one would know. My husband said, “You agreed to marry me and you have to put up with [this situation] ....I needed to talk with someone who did not know my husband. I couldn’t talk with my friend. I only know one woman, and her husband is friends with my husband, so I couldn’t tell her my feelings because I was afraid she would inform her husband. He did not allow me to go out alone. He always said, “I am afraid you will get lost”. I had no friends. I was alone....These were difficult days. I was alone, without real friends, no one around me who I could tell what I felt (Amina).*

*Here I was crying without any reason. I didn't know why I was crying. Perhaps it was because I was depressed... Originally I was crying from isolation before the pregnancy, and it got worse with the pregnancy, because I was worried about the baby (Hiba).*

Common to the feelings expressed by all the women were their longing for their families, and homesickness. It was hard for them to compare their present with their former life. Furthermore, relationships within Arab Muslims in the UK were seen to be different from those in their own countries. The women described the situation as hard and stressful:

*At the beginning when I came, I did not know anyone here, so I was depressed... Nevertheless they take the place of my family. Here everyone is busy. Even my own countrymen have changed here: they are not like they are back home. This bothers me. I expected everyone to be with me, but the situation is totally different (Amal).*

*The problem here is missing your family. You need them during this period... Here the door closes on you; no one asks about you, everyone is busy with work and how to get money. Sometimes if I was tired I went outside and walked in the street. If I fell down or died, people would see me. I wanted to find people like in my country [i.e. Algerians] here. They are close to each other; they will not leave you alone, and they offer help without asking (Amina).*

In Arabic tradition, childbirth is a cultural transition. It is a time for supporting the new mother socially and emotionally. On migration, women lose the intensive level of care offered by the females in their families. They described how they missed this support, especially that of their mothers, during childbirth:

*In Egypt people are always with each other. Especially if you are pregnant, all your relatives will help you. I miss this here (Hiba).*

According to the women, they missed their families especially during the postpartum period: they longed for the nurture they would have received in their own countries. They asserted that a husband's support and help was not equivalent to a mother's. They detailed the

differences between the postpartum experience in the UK and in their own countries, where family support was available:

*When I went home he took care of me, but not like my mother. I miss her. If she were beside me I would feel more secure... In this respect it was unpleasant. A woman likes to be pampered after delivery, staying in bed and being served by the people around her, and feeling the sympathy of her family.... Sometimes I feel tired. I can't take care of the baby. I am afraid to hold him and hurt him. If my mother were with me it would be different. If I were with my family I would rest, just sleeping and being comfortable. They would take care of the baby and cook for me (Hadeel).*

Even with a husband's support, the women's joy in the delivery was generally tarnished. They expressed a need to share the joy with their families:

*It is really nice to feel the compassion of the husband, but nicer for her family to be around her and take care of her and the baby....The woman likes to feel pampered, [with] all her family around her, sharing her gladness [in her baby] ... I expect that if I had delivered in Jordan they would have taken more care of the baby. I missed all these things.... The baby and I have lost this especial care, and this still upsets me. (Hadeel).*

The mothers of two of the women came out from their own countries to help them during labour and the postpartum period. These interviewees described their happiness and their enjoyment at this time. Their mothers' tremendous help enabled them to cope easily during the first six weeks after delivery:

*It was very important to me. She did everything; I was tired and in pain and it was impossible for me to cope alone. She cooked, cleaned the house and took care of the baby.... My mother supported me at this time (Hiba).*

*The presence of my mother made a difference, [because] the role of your family is the most important. Thank God I feel happy that my mother came.... I can say after this experience that every woman in delivery must have her mother come, or she must go*

*back to deliver in her own country. This must happen with all migrant women. It is unfair to deliver alone without support from their mothers or sisters (Kawther).*

The participants told of the support they received from other Arab women who lived in the UK, and how it helped them to deal with postpartum hardships. Nevertheless, they still believed this support did not take their families' place in this respect:

*Arabs here are practical. They were sending me food and not coming here, but they are certainly no substitute for my family. I did not feel happy as I would if it were my country.... I was under pressure because no one from my family was with me (Fatima).*

*I was tired during first two weeks and did not get out of bed. My friends and neighbours sent me food. They came in the morning and cleaned the house. They also took care of my elder daughter from morning until evening. I only took care of the baby (Amal).*

According to the women, in the absence of family support it was the husband who was the only source of help for women during their confinement. There were significant differences in the women's postnatal experiences. In this study, five women had supportive husbands; this made the postpartum period run more smoothly:

*My husband helped me in the postpartum period. The husband is the only person who can support the wife when she emigrates. In her own country her mother and sisters can do that, but in another country all the responsibility is on the husband. The woman feels weak if he does not support her. It's a real problem (Amal).*

Two women described their postpartum experience as an arduous and confusing period, with unsupportive husbands. It was made even worse for them in that they were unable to rest for one week following birth. They said that they were not just worn out with demands constantly made on them, but that they sometimes felt sad, tense and depressed:

*The first day I was discharged from the hospital I stood in the kitchen cleaning the dishes. Imagine that you are confined and tired, and you have to clean the house.*

*When I had well-wishers I had to stand up and entertain them. I didn't have my mother or anyone [else] around me. Besides, the baby is too much of a strain. Every three hours he needs breastfeeding, even if he was initially quiet. This transitional period is very difficult. You are trapped if the baby cries; you [have to] leave everything in order to attend only to him. You can't live a normal life. I feel that I can't control the situation.... [My husband] did not help me very much. Arab men are not obliging in this regard.... I felt that I was responsible for everything. He helped me in [only] one respect after delivery: if my friends did not send food, he did not ask me to cook, [but] he brought readymade food. But the things I was expected to do, I had to do by myself. He was not used to cooking or cleaning (Hadeel).*

There were however benefits to emigration. In the absence of family support, the husband had the opportunity to be present during the delivery. This is impossible in Arab countries. The wives recorded their husband's comments about attending the delivery:

*He told me, "Now I understand why the Prophet Mohammed said, 'Your mother, your mother, and your mother, then your father, and the most you can do for your mother does not equal the pain from one contraction'. Surely our Prophet was right. The mother suffers a lot during labour. She is born again after delivery." He started to feel more sympathy for me after the delivery (Fatima).*

*He said, "Glory to my God the Greatest, new life will be written to women after delivery." [It is] really as they say: labour is like life and death. He appreciated how much women suffer during delivery (Kawther).*

Migrant Arab Muslim women, like all pregnant women, accessed maternity services. Sometimes they were confronted with another type of isolation, that of language. All the women in the study emphasised the importance of good communication in childbirth. Some of them did not speak English, which made them feel very inadequate.

At the beginning of my study my first supervisor arranged for me to tour some hospitals and maternity centres in the same city where my respondents lived. I met the Head of Nursing in one hospital and asked her about the possibility of offering interpreters. She replied that she could not do this for women with poor English skills because it would be too much strain on



the budget for very few women. She could improve services for many more women with the same amount of money. Her argument was quite logical, but completely ignored considerations of compassion. It is obvious that the difficulties faced by women during childbirth will only be compounded, as will her insecurity regarding both herself and the baby, by the language barrier.

The women, who were not fluent or confident English speakers, reported that they used their husbands as interpreters. Amina was the only woman in the study offered interpretation by telephone, and that on only one occasion. She described her feelings when the midwife offered an interpreter:

*It was as if I was drowning and she saved me I was suffering all the time the midwives were talking to me. They asked me questions I couldn't answer. I was worried about the baby. They decided that I should have a caesarean and that I should deliver before the date [i.e. prematurely], I don't know why. She sensed that I had problems but she couldn't help me. I was always crying and depressed, and only looked desperately at her (Amina).*

The women talked about the difficulties involved in the husband acting as interpreter. It is part of Arabic culture that bad news is kept from women. In addition, the husband sometimes feels shy about asking the midwife questions regarding certain matters, even at his wife's request:

*I sensed that there was something wrong with the baby from my husband's and the doctor's facial expressions and this made me more anxious, because I could not understand everything they said. I told my husband to translate everything for me but he did not. He was hiding the truth and trying to comfort me. (Fatima).*

*My husband also did not want to ask all the questions I want him to [because] he felt shy about them, but they were important for me. What worried me did not worry him. During my pregnancy I prepared a list of questions. My husband said that these questions were not important and not to worry about them (Kawther).*

Even the women who had a fair understanding of the language used by midwives complained of the unfamiliarity of medical terminology and the difficulty in understanding the English accent, because the healthcare professionals talked so fast. On the other hand, the women appreciated the midwives for their way of delivering the information:

*I don't speak English fluently but I can communicate with them. The problem is that they talk fast, but I say to her, "Sorry, I can't understand you", and she repeats [what she has said] (Hiba).*

*I mostly talked with them in English, and my husband was always with me. If I did not understand some of the medical terms my husband explained them to me... In general, I understood everything she said... I did not have any drawbacks in communication with her, and if an Arabic midwife had delivered me, she would have done no more (Hadeel).*

*I understood them a little, but I couldn't answer them properly. Some of the words were difficult for me [because] they used medical terms that I couldn't understand. Even my husband sometimes said, "Stop what do you mean? I don't understand" (Kawther).*

Labour was the worst time for the women with poor English. They were afraid that they could not cope with the stress at this point because of miscommunication:

*I was so scared of not understanding the midwife's instructions so that I could not deliver, I was afraid that my husband would not translate correctly for me, I was asking her through my husband whether I was doing well. I did exactly what she said. I kept asking her. She said "push, push", and I kept doing that even after the head of the baby out, because I was afraid the head will get stuck inside. Then I discovered, after the head came out, that there was no need to do any pushing... (Amal).*

Communication is the most important component of effective maternity care. Good communication allows women to fully understand midwives and be confident in their care during childbirth. Communication problems, on the other hand, make the women felt insecure when delivering in a foreign country with a different language:

*....I was not happy. I felt that it would have been better if I had delivered in my country. At least I would understand what they were talking about, and I could deal with them. For example, I tried to explain to the midwife that the reason I was scared was because I can't stand anyone putting their finger into me, but she carried on examining me. My husband was telling her this but it is different when it is coming from you. She thought that it was only my husband who wanted it (Hiba).*

The women were unanimous in saying that they received many booklets and pamphlets during pregnancy and after delivery. Paradoxically, the problem was still the lack of appropriate information, as all the literature was in English. This inaccessibility of information was hard on the women, who needed their husbands' help in translation. This disconcerted them:

*On her first visit she gave me many booklets, but all in English, nothing in Arabic, so I had to wait for my husband to be free to translate them for me (Amal).*

*I always asked my husband for an explanation. Sometimes I felt shy and afraid to burden him with my questions. It is better [for the booklets] to be in Arabic. I like to learn by myself. I am alone here, none of my relatives [are here to] guide or advise me, so there a booklet would help me (Amina).*

In the main, the women agreed that they had enough information during their childbirth. The problem was the absence of bilingual information. In the absence of the resources in their own countries in terms of family support and knowledge, such bilingual material acts as a source of information. Kawther explained the benefits of bilingual information:

*When they gave me the booklets I wanted to read them. It should be unnecessary to ask my husband to read it for me [because] he is already busy in his study. If they were to translate them into Arabic beside the English text, I could understand the words, and when I want to ask the midwife [about any points] I could mark [the passages] and she would see what the English [text reads] and know what I meant. This would be easy and would not cost much money (Kawther).*

The women faced a strain on their emotional and mental wellbeing during this period. Some of them complained about stereotyping by healthcare providers, and how this increased their suffering and affected them deeply. In the next section, discrimination in maternity services will be explored.

### **6.4.2 Discrimination and Prejudice**

One issue discussed during the interviews was exposure to some kind of discrimination during the period under study. There were different views about this issue. All the participants wore the hijab<sup>7</sup>, and one wore the nikab<sup>8</sup>. Some of them said that clothing, which made the fact of their being Muslim women obvious, caused some problems for them:

*Sometimes I am annoyed when I go out because people look at me. I feel that my appearance is a little strange. Mostly, people are reasonable. Before I came I thought that I would be treated badly, but I now feel that people are nice. Only their views annoy me, perhaps because my appearance is different....When I went to the hospital I felt that the veil created a problem for me. The problem was not that I am a Muslim woman, but that I am a veiled woman. Their attitude [towards me] annoyed me (Hiba).*

*The difficulty for me here is when I go out, because I am a veiled woman and cover my face so that only my eyes appear. The people look at me suspiciously. Sometimes they even say nasty things to me. In the beginning I did not understand what they said to me, but after I took the English courses I started to understand a little of what they said. I only studied for four months. They abused me and this made me upset. Once I was in a shopping centre and there were two old women looking at me. One said, "What is this, it is a male or a female?"....It depends on the person. Sometimes they are kind and jovial, and sometimes they are unreasonable. Before my pregnancy I was treated here for infertility by a British doctor, He was wonderful (Fatima).*

Some of the women were thankful for the healthcare providers. They were satisfied with the midwife's treatment, as one woman affirmed:

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<sup>7</sup> Hijab: The traditional head scarf worn by Muslim women to cover their hair.

<sup>8</sup> Nikab: The covering of the face, leaving only the eyes visible.

*I feel that they dealt with everyone the same way. I don't think that they considered the veil to be an obstacle. During my first pregnancy, when I had an appointment with the midwife, she was always smiling. I was infected by her happiness, her gladness and her optimism. I started to smile constantly. They were good-humoured, and this was a positive attitude about them that I liked. I never felt discriminated against on the grounds of my race. On the contrary, I felt that they respected our religion. In the midwife's first home visit she said "Al-salaam alykom" in Arabic instead of "hello" (Amal).*

In contrast, some of the participants felt angry about how they had been discriminated against by their midwives, and this adversely affected their memories of childbirth in the UK. Among several such episodes, I have selected the case of Rahma because it reinforces the idea that some midwives have preconceived ideas about Asian women, such as that they make too much noise when they are in pain or discomfort because they have a low pain threshold. Bowler (1993, p166) discusses this stereotyping of Asian women by some midwives, using phrases such as "making a fuss about nothing" to describe their behaviour. The following example supports Bowler's observation. The midwife's prejudices limited her willingness to communicate effectively with Rahma and affected the proper course of her labour. Furthermore, this example confirms how such women become identified by their ethnicity:

*...The midwife was not with me. I was having strong contractions and I couldn't stand the head coming out. [So] I rang the bell and she came. She spoke to me in a very unfriendly manner and said, "Don't scream, inhale the gas" in an apathetic and rude way, like a machine, without any shred of humanity. I asked her where the midwife was [because] the head would [soon] be out. She replied that the midwife was busy and couldn't come at the moment; she would be late. I told her again that the head would be out [at any moment] and she said again, "Inhale the gas". Thank God the midwife came by herself; she did not want to call the midwife. The manner in which she talked to me was very bad, and I really hope that I can go back to hospital and ask her why she treated me like this.... It was clearly because I am a Muslim and wear a veil. It was obvious from her manner....In the room beside mine was a British woman. From the time she entered until she delivered she was shouting and she [i.e. the nurse] always came and talked with her. I heard how she was laughing with her*

*and how she tried to assuage her fears and pamper her. I am sure she was the same nurse because she was in that area and I heard [i.e. recognised] her voice. Why did she treat only me like this? She was prejudiced....she was British. It was clear from her appearance' (Rahma).*

Many of the women believed they received helpful attention from the midwives during labour. Nevertheless, the problem was that there was still some remnant of prejudice on the part of some midwives which they could not hide:

*She asked me what I would call the baby. I said Mohammed, and I sensed from her facial expression that she was annoyed at the choice of name (Fatima).*

In association with comments about mistreatment and prejudice, some women reported that the midwives perceived them as demanding and complaining. In interviewing the women about the care in postnatal wards, they said that they did not receive help from the staff and felt mistreated. One woman complained:

*They kept the baby with me the first day. I was tired and I couldn't move or breastfeed the baby but they did not help me. They came and checked me only if I asked them to. When they sent me to the postnatal ward my baby choked and started frothing at the mouth. I rang the bell more than once until they came. I said, "Look at the baby! I can't move [him] or hold him." The nurse was nervous with me and answered curtly, "What do you want". I said angrily nothing, thank you..... She sensed that I was unhappy and came back again and asked me what I wanted. I told her to check the baby. I was afraid for him. She said that this was normal and not to worry. My breast was hurting and I couldn't feed the baby. My nipple was cracked, but they did not help me with that (Fatima).*

Two participants complained of severe depression after their discharge from hospital, because of the racial intolerance they faced during their childbirth and their stay in the postnatal ward:

*Unpleasant experiences like this will affect her life adversely. There are lines they must not cross. We are also human beings and know our rights (Kawther).*

On the other hand, the women also told of their suffering under the routine of the maternity system, as well as complaining of the emotional coldness of the midwives' manner which is totally different from that of Arab health staff. In more detail, bureaucracy and "stiff upper lip" contributed to this difficulty

### **6.4.3 Bureaucracy and 'Stiff Upper Lip'**

Some of the women complained about the bureaucracy of the maternity system in the UK. Infertile women suffered especially under this system's routine.

*The problem was the system here. It is very slow. We waited for about a year to start the treatment. I told the doctor that I had had all these tests and I had all the results, so let's start the treatment immediately and not waste time in investigations. The doctor said, "We can't. We have a system here and we must follow it. We will start from the beginning." And they repeated all the tests I had done before (Fatima).*

Fatima described her torment as she tried to find someone to consult with about her condition during pregnancy. She could not contact her obstetrician because her appointment was still not due, and no one reassured her because this was simply the routine in maternity services:

*At that time I was preparing to go on vacation to my country. I went to the GP to give me an appointment with the obstetrician so that I could consult him, [but] he refused. I was afraid to fly in case this affected the pregnancy, and I asked for the address of a private obstetrician. I was [also] worried because I had taken medication while I was pregnant. No one answered me, or reassured me. They told me to wait until my appointment [because I had] to follow the system (Fatima).*

One of the problems the women complained of was the emotional detachment of the healthcare providers in maternity services. Arabs' non-verbal behaviours can prove more eloquently than any conversation. Their attitude and posture can exhibit their true feelings without saying anything. UK professionals sometimes answered questions automatically, without eye contact or facial movement. This attitude was perceived by some as a lack of respect. Some of the women felt that in certain situations they were ignored or treated as inconveniences:

*In reception there were two nurses. The one who talked to me was so cool, unflappable, and abnormal in her coldness, like a wall, as if a machine was in front of her.... I just wanted to tell her what happened, [but] she did not give me the chance and started asking questions in an automatic way without any kind of supportive attitude or amiability. [She was] very, very cold, prejudiced, as if she abhorred [me]. I was amazed as to why she behaved like this, but I said to myself that this was not the time to ask her, “Why are you treating me like this?” (Rahma).*

*They are unemotional and practical here, while we are sentimental by nature. She was telling me that the baby was unhappy and that we had to deliver it immediately, which was true, but she was saying this to a woman who was delivering and in pain. This was my baby – what more could I do? She demoralised me. I understood what she said but I couldn’t tell her what I wanted (Hiba).*

Most of the women agreed that the attitude of healthcare staff in the UK was cold-hearted. In Arab countries caregivers are friendlier and good-natured. As a result, care in Arabic countries was regarded more favourably. It was obvious from their narration of the annoying things the women faced during their childbirth. One woman complained that:

*The problem was their cold treatment – they were unbelievably cold....In Jordan they are friendly towards women. They keep coming and checking you all the time, with smiles on their faces (Rahma).*

Another challenge the women noted during their interviews was that of cultural differences between the Arab Muslim tradition and the practices of midwives here. The following sub theme highlights some aspects of this conflict.

#### **6.4.4 Conflicting Views on Treatment**

To confirm a pregnancy in an Arab country the doctor performs a pregnancy test and scan between four to six weeks. They do not taking the woman’s assertion that she was pregnant for granted. They use the scan to check for problems. During my work experience in Jordan and Oman, many cases of ectopic pregnancy were discovered and treated before any serious



complications had arisen. I have not managed to ascertain here how such pregnancies are discovered before a 12 week scan is carried out. As Arabs regard pregnancy very seriously, it is essential for an Arab woman to confirm the health of her unborn child. It is easy to imagine a situation in which the woman and her entire family think she is pregnant, only to find out after 12 weeks that this is not so, or that she has miscarried. This dilemma can be avoided by conducting a scan at six weeks. The following quotes reveal the women's uncertainties regarding pregnancy:

*I was not sure that I was pregnant because the GP did not do any pregnancy tests on me. She made that decision from what I told her. Me and my husband were afraid to inform our families because we were not sure and the GP said, "We will give you an appointment with the midwife" (Hiba).*

*When I knew I was pregnant I went to the GP to make sure. I thought they would do some tests for it, as happens in my country. The GP only asked me when my last period was, and he decided I was pregnant even though I always had irregular periods. He decided this only from what I said; I was not sure and went there for reassurance. Without doing any tests the GP made an appointment with the midwife for me, so that I would start the follow up with her (Kawther).*

As previously mentioned, pregnant women receive more attention in Arab countries than they do here, where pregnancy is regarded simply as normal. Doctors and midwives in the UK do not counsel expectant mothers to take any precautions:

*They always said not to overwork, not to wear high [heeled] shoes and not to go up and down the stairs. As you see, in my home here are stairs, not like in our houses where everything is on one level. I was so afraid of a miscarriage for the first few months. In our country they impress on you how serious pregnancy is, but here it is different. When I asked the midwife here she said it is normal to wear high [heeled] shoes and to go up and down the stairs, but slowly - don't run or jog. I can do everything, but I must not overexert myself (Kawther).*

*Here I learned the normality of things during pregnancy: you live normally, without making any allowances. In my country, there is a list of forbidden things (Zahra).*

*They are different here. The doctor told me to move around and to do some exercises. This is absolutely not allowed in Egypt. I went there when I was two months pregnant and the doctor advised me not to move and to rest completely because of the discharge of blood spots that I had.... I was worried about the discharge of blood spots. I tried to rest, but when I phoned my family they told me that it was dangerous and that I had to rest completely. The doctor here told me that it was normal (Hiba).*

Some of the misunderstandings between Arab Muslim women and midwives can be ascribed to different views of treatment. Arab women are taught to ensure their safe passage through their labour by having plenty of rest and nourishing food and keeping warm, avoiding exposure to cold. However, midwives in postnatal wards here did not conform to these requirements. Modern midwifery practice encourages new mothers to move immediately after giving birth. The women in the study expected to receive help in the postpartum wards, whereas British midwives expected them to take care of themselves and their babies after delivery, as doing so was considered to promote good health. UK hospitals encourage a close attachment between mother and baby by arranging for continuous contact between the two in the same room. The women in the study were dissatisfied with this "rooming-in" policy because they were used to babies being kept in nurseries in order to encourage the mother to rest. This policy did not meet the women's expectations of care in postnatal wards:

*On the first night I was so tired [because] I [had] lost a huge amount of blood. I bled after delivery and they wanted to give me a blood transfusion. They kept me in the labour room until night time for observation. During the night they sent me to my room, gave me the baby and said, "Breastfeed him". I breastfed him a little and couldn't continue, I was so tired. I couldn't hold him; He was heavy and I couldn't hold him. She said, "Okay, this is normal. In time it will become easier for you. I said that I knew how to hold him but I couldn't: I had no control; I felt that he would fall down. I was so afraid for the baby... In this case the baby should be in the nursery. If they refused to discharge the mother, this meant that she needed care and rest. So why didn't they keep the baby so as to take care of him? They knew that I had fainted twice while I was going to the toilet. I had to change the baby and breastfeed him and I couldn't.... She refused to take him, and said that no one was in the nursery room, and she was tough with me. She was not cooperative. She meant that in the hospital*

*you have to take care of yourself. When you are in the hospital [, however,] you need them to help you, not to put you under pressure (Kawther).*

Most of the women were critical of care in the postpartum ward. They felt ignored and frightened by the unfamiliar type of care they received, especially when compared with their own countries. This led the women to trust Arabic doctors more, and go for checkups again when they went back:

*In our country, after delivery the nurse comes and does an abdominal massage several times on the first day and checks you, [but] here they didn't. They only gave me many booklets about the exercises I had to do after delivery and how to take care of the baby. Even though I felt strange, they did not check the stitches. Because of that, when I went to my own country I visited the obstetrician, and asked her to check the stitches [because] I not feel comfortable with them. I did not feel confident when I was in UK (Fatima).*

*They did not come frequently to check you like [they do in] in our country; you feel that they wanted to finish their job with the least amount of effort (Rahma).*

One of the women's practices was making the baby wear a cap even inside the house. As the biggest part of the baby is its head, which loses heat easily, they always put a cap on, as well as two or more layers of clothes, to keep the baby warm. These practices were criticised by the midwives:

*For us we have to wear the baby cap indoors for forty days, [but] the midwife said, "Your house is so warm; you have to remove the cap from the baby's head." I didn't remove it. As a mother I know what is best for my baby. (Kawther).*

*When the midwife came she said, "Your home is so hot. Don't put a cap on the baby's head." For us it is basic for the baby to wear a cap, especially for the first six weeks (Fatima).*

Some of the women said the healthcare providers were indifferent. They talked about how the staff disparaged their worries, and thought they understated the seriousness of the symptoms.

What health professionals saw as minor problems were viewed by Arab Muslim women as serious conditions. More than one woman complained that in the UK they did not treat physiological jaundice the same as in the Arabic country. They interpreted this as lack of interest on the part of the staff. Hadeel told of her suffering as she sought treatment for her baby's jaundice; she did not feel secure until she went to her country and her baby was examined by a paediatrician there:

*When I delivered, the baby had jaundice. The midwife visited me three times. Once the baby was quite clearly yellow. I informed her and she said, "Just put him in daylight", and she didn't do a test. Another day she came and he had become more yellow. I asked her to do a test on him; she said, "It is normal", and only put him in daylight. They gave me a [telephone] number to call the hospital if I needed help. I let my husband call and they said, "We will send the midwife to check the baby". She saw the baby and said, "It's normal". It was obvious that he was so yellow, and I was sure the bilirubin level was high, but she didn't care. When I went to Jordan after six weeks I took the baby to a well-known paediatrician for a full check up in order to feel secure about him. He said, "Your baby has jaundice and if you did a test on him now the bilirubin level would be more than ten according to what I can see....They have to be more serious about some things instead of saying that everything is normal. The doctor coldly said that it was quite normal for jaundice to stay for nine weeks without needing any action. I am not a specialist but when I read about it on the internet, I know it is very dangerous and can affect the baby's brain. Here they consider it normal, while in Jordan they treat it (Hadeel).*

The most difficult period for the women was their stay in the postpartum ward after delivery. They suffered from the quality and quantity of the food. Another problem was the sharing of rooms with other new mothers, but the worst thing was the shared toilet. The following sub theme will explain the women's feeling.

#### **6.4.5 The Conventional As Strange**

Migrant women hold to the beliefs and practices of their home cultures regarding pregnancy and childbirth, such as eating the right quality and quantity of food, taking enough rest, maintaining privacy, and being cared for during childbirth. These practices were difficult to

maintain in hospital. The women had several complaints about their stay there. They were dissatisfied with the food, the shared rooms and the shared toilets. They felt that maternity services in these respects did not cater for their specific needs.

The right food was an important aspect for the women, all of whom stated that they were not offered Halal food during their stay in hospital. In addition, Arabs believe that it is essential for women to have hot drinks, especially soup, after delivery and nutritious food. Without Halal food, the women could not eat meat or chicken:

*I did not see anything written about Halal food. They put the food in the kitchen, and you would go and put it on your plate. Some kinds of food were marked vegetarian, so I could only take those. I suffered a lot because of this.... I was so hungry. I did not find anything I could eat. Nothing suited me. There was mince meat with sauce, and I couldn't eat meat that is not halal. There was cauliflower with cheese, beans, mashed potato, tea and coffee. There was no soup or rice. I know that every hospital serves soup. Even in our country in government hospitals it is essential to serve soup; this is my story with food (Kawther).*

The second complaint about the food was the small amount and the lack of the variety that Arab Muslim women are accustomed to. All the women who stayed in the hospital were given food from outside the hospital:

*The food was bad. The amounts were small, and you know how hungry you are after delivering. The lunch was boiled vegetables and potatoes. It was not nice. My mother brought food from home for me (Hiba).*

*The breakfast was bad. It consisted of a cup of milk and tea, two pieces of toast and two small pieces of butter like samples. They brought the food for me.... They call us Third World, but according to their treatment we are an advanced country. The simplest example is the breakfast: [in our country] there will be a variety of juices, cheese, egg and jam. The breakfast makes you feel full (Rahma).*

The food was not suitable for Arab women. They said it consisted of those types of vegetables that cause abdominal distension. New mothers are not allowed such food because

they believe that everything is transmitted to the baby through the milk, including potentially harmful foods. Even if the mother felt hungry between meals and during the night, they did not offer her food:

*The food was unhealthy and there were not enough different kinds. You felt that the food was only for British people. It is unreasonable for a woman who has delivered to eat mashed potatoes and legumes like beans, [because] they cause gas and affect the baby. They put six or seven very limited kinds of food... no snacks between meals.... I went there and the fridge was empty. I found only toast, two empty packets of butter, no jam, and no milk. I was feeling hungry but I couldn't eat only toast, and you know how hungry women feel after delivery. How is it that, in a big hospital like this, they do not serve enough good quality food? (Kawther).*

In Arab countries it is usual to serve women food in bed. It was unusual for the woman to have to go to the kitchen to get her food:

*The care was bad. After delivery they inserted a urine catheter into me for three days. There you had to help yourself. I had to walk to get my lunch or dinner with the urine bag. If I did not bring it, no one would ask if I had eaten or not (Fatima).*

*You were tired after delivery and couldn't walk because of the sutures. They came and said that food was coming, [you can] go and eat. You had to walk a long distance to eat. At lunchtime I had no company, and my husband was still not with me. I was tired [because I was] awake the whole night with the baby, and they said, "Go and get food".... This was the worst thing. (Kawther).*

The second irritation was the shared room. The women complained they could not sleep after delivery because of the other babies in the room:

*The care was good but sharing a room annoyed me. You couldn't be comfortable [because] there were disturbances on every side. If another baby cried, you would wake up and then your baby would wake up and start crying [so that] you couldn't sleep (Hadeel).*

There were no private rooms, even at a price.

*There were no private rooms; they were all full when I asked for one, and this was annoying. You couldn't sleep, the babies were crying, and your baby would wake from the crying of the others..., I asked for a private room, and [said that] I would pay extra money for it. I would feel more comfortable, and I don't like to share the toilet with other women, but they did not offer me a private room. (Kawther).*

Because of the non-electric beds and uncomfortable mattresses, the mothers could not sleep. Moreover the care was bad: the linen was not changed, as is surely necessary for any patient. This was a bad situation for a woman who had just given birth; it is well known how much blood is discharged after delivery:

*They also did not change the linen every day. I stayed for three days[, and they only] changed it the day I went home. ... I suffered also because of the bed. The mattress was not comfortable at all. My back was hurting me because of it. I was turning over and over all night and couldn't sleep. The bed was not electric. It was manual, so someone had to elevate the bed for you if you wanted to sit up or breastfeed the baby. When my husband was with me there was no problem, but the drama when he left! I would ring the bell but they would not answer. I stayed in the postnatal ward for three days (Fatima).*

The shared toilet also caused problems for the women. Muslim views about blood have been mentioned; it was disgusting for the new mothers to see other women's blood on the floor. The shared toilet was a source of infection, especially for woman whose immune systems had been depressed after delivery:

*The toilet was shared. It was so disgusting, especially with women who had delivered. It was not always clean. They clean the toilet [only] at certain times.... Yes, it was a problem: one toilet for many women. Every time I went there I took Dettol and wiped it clean it before using it. I was afraid of catching an infection or something dangerous. Most of the time the toilet was clean, or [perhaps] it was my luck to go immediately after they cleaned it (Kawther).*

*The toilet was disgusting. There was blood on the floor. Thank God I did not use it because I had a urine catheter. I only used it to change the nappy. On the last day they refused to discharge me until I urinated. I told the nurse that I couldn't use the toilet but she insisted. They put tissue and antiseptic [in the toilet]. I cleaned the toilet and used it (Fatima).*

It was inconvenient for Muslim women to share the toilet: because of the religious demand for modesty, they must always wear the hijab when using it:

*It annoyed me because I am a veiled woman: I always have to cover my body and head if I go to the toilet, and I was afraid that someone [might] see me along the way; it was difficult for me as a Muslim woman (Kawther).*

Women accessing maternity services in the UK are confronted with many challenges. The participants started adopting new strategies to live as harmoniously as possible in their new world; they reacted differently in order to adjust to life in the host society. They described the difficulties they encountered in this new setting and the changes in family dynamics. The women constantly compared and contrasted their home culture and that of the West. Ultimately, they discovered defects in some aspects of the former, and developed an urge to reject some behaviours as inappropriate for their new surroundings. It would be expected that they would use various ways of coping to overcome the challenges they faced.

## **6.5 Adaptation to The New Culture**

The emigrants made cultural transitions when they moved to a new setting. They started changing some of their beliefs and practices, and adhered less to the cultural beliefs of their homelands. The women in this study discussed the alternative models they used to cope in their new lives. These models are adaptation to care, change in gender roles, and adaptive behaviours.



### 6.5.1 Adapting to Care

The issue of female doctors emerged as a potential challenge for Arabic Muslim women in all the interviews. Participants had two views; some clung even more fervently to the need for examination by a female doctor, and did not accept the presence of male doctors during their deliveries:

*I will not agree because a female midwife/doctor is available. This is not only a religious request but it is also a cultural one. In my country there are male obstetricians and some women go to them, but as for me I will only go to a female obstetrician (Amal).*

*The first time I went for a scan I had a male doctor. I was scared of him, and I did not feel comfortable with his uniform. Then I asked for a female doctor and told them that, if there was not a female doctor next time, I would not do the scan. They give me another appointment and I phoned them before I went and I said that I hoped it would be with a female doctor. Thank God there was a female doctor (Kawther).*

The other approach adopted by some of the women was that they endeavoured to be seen by a female doctor, but would agree to a male if no female were available. It is a personal issue, not an Islamic requirement. All women in this study wore the hijab, and found it difficult to expose themselves to a male:

*I prefer a female doctor, but if she is not available I would agree to let a male doctor examine me. My first appointment was with a male doctor. He said, "I will do a Pap smear - is this okay with you?" If I had refused, they would have given me another appointment after maybe six months, so I said that it was okay and he did it. Me and my husband understand that we have to adapt to our circumstances.... I feel more comfortable with a female doctor. The presence of a male makes me embarrassed. I feel afraid and shy of males, especially if they examine sensitive areas. We are brought up like that. It is difficult for us to change. (Fatima).*

*I feel more comfortable with female doctors, but if there is a necessity for a male doctor I will agree to be examined by him. All Muslim women ask for female doctors because we don't like to be seen by males. But if there is no opportunity and there is a*

*risk to our life it is halal in our religion to be seen by male doctor. We have to save our lives (Zahra).*

Childbirth is regarded respectfully as part of the female sphere in Arabic countries. After emigration, their new social circumstances impel them to break with traditional norms and cope by allowing the man to enter the women's sphere because there is no alternative workable solution. This coping model will be discussed in detail in the next subtheme.

### **6.5.2 Changes in Gender Roles**

The husband is the only one who could help the woman after migration. This new role for the husband was extensively discussed in the interviews, and the women openly described their feelings of happiness at the prospect of their spouses entering their spheres, a change that brought benefits to the husband-wife relationship as well as the attachment between father and child:

*He started to help me with cleaning, he took care of my son and he let me sleep during the day.... Here in a foreign country he takes her mother's and father's – in fact, the whole family's – place.... In Saudi Arabia he was not anxious about me and the baby as he was here because all my family was around me, and when I was discharged from hospital I went to my father's house. He was not involved with us as he is now. The situation here is more worrisome. He took more responsibility. I even feel that he loves this baby more (Kawther).*

Many women appreciated the fact that their husbands became more involved in their pregnancies than they might have been in their homelands. The absence of female support in the family gave the husband a chance to enter a field that had been closed to them:

*My friends in Egypt stay with their mothers during pregnancy. Their husbands come in at night from work and their mothers take them to the obstetrician for check up.... If I was in Egypt he would not feel this. He would be waiting outside and would [only] hear when I had finished. Here he was with me holding my hand. He felt my suffering. His relationship with the baby is strong...In Egypt the husband definitely does not*

*interfere with the wife's care after delivery. At first you are in your family home and when you get back home your mother will not leave you. She will cook and help you with the baby. Here there is no one to help you, and because of that he has to help me around the house (Hiba).*

Others, however, felt uncomfortable and even ashamed that their husbands demeaned themselves in this way. For them, masculinity had nothing to do with cooking and housework:

*My husband helped me but he didn't know how to clean the house. Once he saw me sleeping so he cleaned the dishes and vacuumed the house. I did not let him do this. I was mortified – how could I let him do these things? In my father's house my mother did everything for my father and brothers. I was brought up like this. The man is too special to do such mundane tasks as cleaning the house, and when he does I feel guilty (Fatima).*

Some women found it necessary for the husband to involve himself in housework in order to support his wife during childbirth. They described it as a coping strategy due to the lack of a workable alternative. However, they were not enthusiastic about the presence of the husband during delivery:

*I want to ask when the husband attends the delivery of the woman, how he sees the whole delivery process. I think the woman loses her allure and her unique aura disappears. My husband didn't know that there is hair on the woman's arms and legs until we were married. How could I let him see me exposed when delivering? He always sees me clean, never nude. For him the pretty model is the standard for beauty. Anything more than is natural is unnecessary. (Rahma).*

*It is not good to let the man attend the delivery. The husband must always see the woman in a beautiful light. We do not let the man see a [single] spot of blood during her period, [so] how [is he supposed to] see her deliver? (Kawther's mother).*

Other women were not convinced of the idea of sharing the experience of birth with their husbands, but once they had gone through it they were happy and contented:

*There are [different] viewpoints on that. Why not? Let him feel how she suffers to deliver the baby. It is not easy at all. And it is strange for an Arab husband to attend the delivery. I asked him not to come in. Frankly I didn't like him to see me in this condition, but he refused. He wanted to stay with me. I thought it depended on whether or not the husband was willing to attend the delivery... Other Arab women told me that our relationship would be badly affected by this [i.e. if he attended the delivery]. My husband insisted that he would attend the labour. He said, "I will not leave you alone". After the delivery I was happy that he attended, (Hadeel).*

*I was not convinced about the idea of my husband being there during the delivery, but through my experience of labour in the USA, my husband was with me to interpret. I discovered the difference between [my husband being there and not]. In my first delivery he came in the morning. I had already delivered. He saw the baby and held it. No one was with me during the delivery. After that, all my family was around me but I was crying, I did not feel that they knew my suffering or what had happened to me.... When I remember, it always brings tears to my eyes. This time and the previous one my husband was with me and he was surprised by the labour pain... My husband became more cooperative and closer to me. I felt it was nice to deliver and have your husband beside you throughout the labour and after delivery. His feeling was totally different toward this baby than [towards] our son (Fatima).*

The majority of the women reported positive feelings about the husband's presence during delivery. They pointed out the significance of these shared moments, and did not think the experience would affect their relation adversely. In fact, they described how the husband changed for the better as a result:

*I think it's odd how some women do not want their husbands to see them deliver. It lets them know how much we are suffering, and they become conscious of that. It is unreasonable that everything is up to the woman.. .. In my first delivery, the moment my husband saw the baby he felt [like a father]. He was crying. I never saw him cry before. They deprived him of this nice feeling, the shock when you see your first baby. He will never feel it again. This feeling is very important for the relationship between the father and his children (Amal).*

*It was really nice. I don't know what would have happened if he were not with me. He knows how much I suffered and he is grateful that I underwent this to deliver his baby. If I was in Egypt he would not feel this. He would be waiting outside and would [only] hear when I had finished. Here he was with me holding my hand. He felt my suffering. His relationship with the baby is strong. He likes to feed her himself (Hiba).*

*Yes, he must stay with her during delivery. Regarding the question of whether this would make him loathe her: if he were to loathe me, let him not make me become pregnant again. The issue is not enjoyment for one hour, but that he must feel with me, be my partner during the exhausting process of pregnancy, and he must witness the delivery and see how much I suffer pain... I appreciated that my husband attended the delivery and we said he must attend future deliveries if we are in our country (Kawther).*

Some of the women described their husbands' feelings after attending the birth. Arab Muslim men were very interested and indeed affected by the experience:

*He told me, "Now I understand why the Prophet Mohammed said, 'Your mother, your mother, and your mother, then your father, and the most you can do for your mother does not equal the pain from one contraction'. Surely our Prophet was right. The mother suffers a lot during labour. She is born again after delivery" (Fatima).*

*He said, "Glory to my God the Greatest! New life will be ascribed to the women after delivery." [It is] really as they say: labour is like life and death (Kawther).*

The woman was obliged to disregard some of her traditional customs in her new environment and adapt her behaviour to her new life.

### **6.5.3 Adaptive Behaviour**

This transition led the women to question several norms of Arabic culture. They attributed their abandonment of some Arabic traditions to many causes.

*I did not practice any of these beliefs because I don't know how. My mother is not with me. I am the eldest in my family and the first one to get married. I have not seen what they do.... I have not performed these practices here because I don't know how (Hadeel).*

*I like to do everything quickly. In my previous delivery I was in Saudi Arabia and I did everything they told me. I felt good about it. Now I have no time. I take one hour to dress my child if we go outside. I don't observe many of these practices because the circumstances here are different (Kawther).*

One thing the women unanimously agreed that they could not ignore was religious belief. If they believed it to be God's command, they had to follow it:

*If there are any religious practices, I do them [because] it is a command from God, and I cannot ignore it... I did the things mentioned in the Qur'an or by our prophet, [but] the things created by people I considered as legends (Amal).*

*We have some traditions and customs not related to religion, and those can be ignored [if you want]. But if it is a matter of halal or haram (allowed or disallowed by Islamic law) I can't ignore it (Fatima).*

One issue that was referred to repeatedly in the interviews was "eye envy". All the women believed in it because it is mentioned in the Qur'an. However, the women considered the cultural practices regarding envy as superstitions and they ceased to regard them:

*Arabs are afraid of envy [i.e. of being envious] because it is mentioned in the Qur'an, and [because] you feel it [i.e. it is a powerful emotion]. For example, when some people leave after having seen the baby, they cry. It [envy] really is present, and we know from our religion that the treatment for envy is the Qur'an. We read some of the Qur'an to our children before we go outside or meet any visitors. We trust in God that this will protect them [i.e. the children] (Amal).*

*In my father's home we only read the Qur'an to the baby and I also did this, but my husband's family is very nervous of envy. My mother-in-law asked me to keep the baby inside when we had visitors, and she brought a blue bead for me to hang on the baby's clothes to protect it [i.e. the baby] from people's sight, but I didn't use it. I only hung a piece of gold with "Glory to my God the Greatest" written on it in Arabic. I believed that envy exists because it is mentioned in the Qur'an, but the solution is not to let my baby wear a blue bead to protect her. This is just legend. I do what our Prophet Mohammed said: support the children by reading the Qur'an (Hiba).*

*Traditionally, we hang blue eye made from gold or silver in his clothes. Some people are afraid of envy, [but] as for me, I only read some of Qur'an to him before any one comes. I don't like any woman to talk at length about my baby or to eulogise him. Once the health visitor came and said, "Your baby is fat and tall; he is over the normal range", and she started talking about him. After she left he cried and cried. I am sure that she envied him. I was upset by her [attitude] (Hadeel).*

The women adopted many coping mechanisms to ease their lives in the new world. But even taking this into account, they maintained that there were still great differences between the maternity services in their own countries and those in the UK. They valued some of these differences while still feeling alienated by others. These differences are encompassed by the following theme, which includes the midwife/doctor roles, normality vs. medicalisation of care, education and the strangeness of care.

## **6.6 Dissonance Between Two Maternity Health Systems**

The birth of a child is a challenging experience for any woman and her family. In this study, childbirth occurred in unfamiliar surroundings, new family structures and different maternity systems. The women's experiences of childbirth as recounted in this study exhibit clear differences between the two maternity services, especially as regards the women's care, notably during pregnancy and labour. Women expected interventionist care of the highest quality and were exposed to a normality driven care model alien to their past experiences and

expectations. The women discussed in detail how these differences in care during childbirth frustrated them. The four main differences were as follows.

### **6.6.1 Midwife/Doctor Roles**

One issue discussed by the women was midwifery care. They described how doctors in the Arab world have a prestigious position. As a result, women trust obstetricians to provide maternity care. In the UK the women were confused when they were treated only by midwives; they preferred to be under the care of obstetricians during childbirth on viewing them as the professional with a higher status and greater knowledge and skills than midwives.

*I am worried about what I heard from my friend who delivered here. She said that the midwife was not a professional and that she would deliver you, not a doctor. If anything happens to you during labour, what would she do?(Hiba).*

*The obstetricians there are better. You can see the obstetrician immediately if you pay. Here there is no need to see the obstetrician if no complication arises during pregnancy. There you are reassured because you are dealing with an obstetrician; you trust her ability as a doctor (Amal).*

However, some of the women in the study did not see care by midwives as a problem, especially after they experienced such care and became aware of the differences between midwives in the UK and those in Arab countries:

*In my first pregnancy I was confused about being examined by a midwife. I asked my husband, “Why the midwife and not the doctor?” Now I have become used to being examined by a midwife. Midwives here have strong personalities and are well qualified to take care of pregnant women. Once she checked my blood sugar and she observed that it was higher than normal, and she immediately transferred me to be followed up in hospital. She made her own decision. She did not wait for the doctor, as happens in our country. The position of the midwife here is higher than it is in our country (Zahra).*



All the women in the study agreed that there was continuity of care by the midwives. They received reasonable explanations if different midwives examined them, which reassured them:

*I am happy and feel comfortable because I am seen by the same midwife. Now that she knows me and the details of my pregnancy, I feel more secure with her, but if she changed I expect that the second one would be like the first one (Amal).*

*Here the same midwife always checks me. At the last visit another midwife saw me and she apologized for that. It is surely much better to be always checked by the same midwife because she knows all the details of your pregnancy, and you will establish a relationship, which reassures me (Hiba).*

The women then discussed the mode of care in the new maternity system. The philosophy of maternity system and the mode of delivering care to women will be discussed in the next subtheme.

### **6.6.2 Normality vs. Medicalised Care**

The women's comparison of maternity care in the UK and in Arab countries revealed an interesting difference in the models of care for childbirth adopted. Arab Muslim women migrants expected medically advanced care in the UK based upon a medical model; being seen by obstetricians and being exposed to high levels of technological intervention. This expectation was based upon their experience in receiving such medically dominated care in Arab countries. In comparison when they experienced care in the UK, they were exposed to a normality focussed model of care, which was unexpected. It could be said that Western care is "Eastern" (at least according to a common Western perception of care in the near and Middle East) and vice versa. This juxtaposition of medicalised care and normality focussed care led by a midwife concerned the participants. They highlighted three contrasting aspects of care all based around the normality focussed principles of maternity care in the UK; the use of drugs and supplements during pregnancy and labour, ultrasound scans, and cosmetic suturing.

In the various Arab countries in which I worked, medication such as folic acid, iron tablets, multivitamins and calcium were routinely prescribed to pregnant woman. It struck the women interviewed that in the UK they were not given many drugs or supplements. They believed that pregnant women and breastfeeding mothers need such supplements for their health, in order to compensate for what they lose during these periods:

*The women themselves advised me to take calcium and vitamin tablets. Here they did not prescribe these for me, but I take them [anyway] (Hiba).*

Pain relief during labour was also mentioned by the majority of women and they exposed a further difference between Arab and UK culture. In the UK participants were exposed to a model of pain management alien to their previous experiences, being based upon the principles of natural childbirth. Care providers advocated that pain was a natural part of the birth process, and that with education, support and reassurance the childbearing woman could control and manage her pain without drugs. In contrast, study participants referred to the large amount of medication they received during labour in Arab countries, in order to both accelerate the delivery and relieve the pain. The interviewees held contrasting opinions about this difference. Those who had only experienced delivery in the UK appreciated the idea of natural birth:

*In our countries they want to finish quickly, so they do things that are more painful. In both cases there is pain, but normal labour pain is less painful than the pain of induction. Now I had no problem with delivery. I knew how my body would act; I knew about labour and could visualise it. If I were to deliver again it would be easy [because] I have had experience. If it were the first time it would be frightening. If I deliver in my country, I will go when it is nearly time to deliver, so that they don't have time to do unnatural things to me. I am happy that my first two deliveries were here. They gave me a good experience of normality (Amal).*

*In Jordan they help the woman: they give her medicine to accelerate the delivery with more painkillers. Now that I have experienced delivery without medicine and [have seen that] it was tolerable and safer for the mother and the baby, I think that to deliver without any medicine is much better (Hadeel).*

This contrasted with the women who had experienced labour in Arab countries, where the mode of delivery used in the UK was still regarded in a traditional light. These women found the experience of birth in their homelands more satisfying:

*I want to talk about an important matter regarding delivery. It is nice that the women deliver normally, and that they keep everything normal during labour, but they must intervene if the woman needs help. You know one woman (X) suffered a lot during labour and got horribly torn. They must not let her reach this stage. They were also very rude to her during delivery. They must evaluate the situation, intervene in good time and treat [the woman] better (Kawther).*

*Here you are more happy after the delivery; your health is better, In a way, the anaesthesia drains you. When I recall the labour pains I feel scared to deliver again in the UK. It is difficult to do it again (Rahma).*

The women also complained about the lack of ultrasound scanning during pregnancy in the UK. Firstly, they were astonished that midwives used tape measures to measure the abdomen length. Then they discovered that the aim was to check the health of the baby. This is a strange practice for Arabs, which is why the women did not feel confident about their babies, as they could not see them to make sure they were healthy. Secondly, scans are more readily performed in Arab countries because women are treated by private obstetricians. Even in public hospitals scans are done frequently, as the women are not satisfied if they do not see their babies, and so may not return for the next antenatal check up. On the other hand the women were happy that here they are told of the sex of the baby, which does not always happen in their own countries, as this is seen as a problem:

*She took the measurement of my abdomen using a meter. I thought this was strange. I didn't know why she did this. It never happened to me in my previous pregnancies. They did scans for me at each check-up..... I stayed in Saudi Arabia for two months and they did three scans on me. I followed up with a private doctor and I was happy with that. I saw my baby and I still could not believe that I was pregnant.... They explained this to me in detail and I was overjoyed to see the baby's face, hand, back and head. (Fatima).*

*Here I only went once for a scan. They checked that the baby was normal and that everything was OK. Here they tell you the sex of baby without you asking them. In my country I went to a private clinic for a follow up. She did a scan every visit, telling me everything in detail and giving me a photo of the scan. Here they only did two scans. I don't know if there are side effects of the scans. Here they check quickly, in my country they tell you more details. For me it's okay, because they say the baby is normal and my condition is normal, so there is no difference with the times of the scans. If there are any complications with me or the baby I would need more explanation – thank God this did not happen to me (Amal).*

*When they do a scan, they are very careful, and take the measurements. Their concern here is to check that everything is normal with the baby, while in Egypt their priority is to let me and my husband see the baby and be happy with it. When I had a scan here, I was thinking that I would enjoy seeing the baby, but they checked that the baby was fine without showing it to me. They also told us the baby's sex (Hiba).*

Of all the aspects of scanning, the women were most satisfied with the level of detail they were given in their home countries. Perhaps the language barriers prevent this from happening in the UK, although those women who could speak English fluently had the same attitude. All the women with poor English skills were accompanied by their husbands who interpreted for them, and no details about the scan were given to them either:

*There is no comparison between the scans here and in Jordan. Here the scan was not clear and did not give any detail. She did the scan quickly and did not take the time to check everything.... she did the scan quickly and only told me that the baby was OK. But this was not the amount of information I had hoped for.... You can see the scan in Jordan better. Obstetricians do scans every month, and reassure you by giving you all your baby's details. They give you plenty of information, and her explanation helps you feel secure (Rahma).*

Aside from the number of scans, the women were dissatisfied with the way they were conducted here. Zahra described her suffering and the paucity of information given her. She described her feelings about waiting for the scan and how she felt frustrated and disappointed

afterwards. She ended with conviction that there is no need to have a scan in the UK because:

*....they do not spend enough time with you or give you more detail. In my previous pregnancy the baby had a kidney problem: the right kidney was small and was not growing. They started to do a scan every month. I was waiting every month for the scan, because I wanted to know if it had started to grow. I cried all the time; the only hope for me was the details of the scan. They did not explain to me in detail. You can imagine the feelings of the mother who knows that the baby has some abnormality and she wants to know what progress [there is] but they never gave me the feeling of security regarding the scan. Every time they do the scan they said to come for another scan next month to see developments. I wanted to know the measurement and what it meant, but they did not explain it to me (Zahra).*

A further aspect of care which differed between the UK and Arab countries related to the use of episiotomy and perineal suturing. In my experience as a midwife in Arab countries, in order to prevent irregular or third degree tearing, episiotomy was routine for the first vaginal delivery and in any delivery using instruments. This was viewed as proper management of the perineum by the women in this study and was a central issue in women's birth experiences. Many women interviewed were worried about stitching in the UK; it is different from that in their homelands. They were aware that women needed some vaginal repair after giving birth. One participant said:

*This time the stitching was different than it was in the first delivery. Then, the doctor cut the skin to help me deliver, so the stitching was straight and in one place. This time they left me and I got tears in many places and it was irregular. Until now it has hurt me and I felt that my vagina is more dilated now because they did not tighten it (Fatima).*

*There is an important thing I want to ask you about. I've heard that here they do not stitch you after delivery, nor do they perform any make up surgery; I don't know if this true or not (Rahma).*

There were many complaints from Arab women about stitching here. They were concerned about cosmetic suturing, a process by which the vagina would be tightened following childbirth, a regular practice in their home countries. Kawther gives a full explanation of this from an Arab Muslim woman's viewpoint:

*I heard from women who delivered here that they suffered from the stitching, [because] they only stitch the tear without narrowing the vagina.... In Arab countries the doctor always constricts the woman to resume her sexual life with her husband as [it was] before delivery. Here they don't do this. This affects the couple's relationship and can destroy many. It is an important issue about which I was very worried. My sister delivered in Saudi Arabia. Her doctor stitched her at the time and repaired her vagina. She was anaesthetised and would have to endure the pain only once, while a woman delivering here suffers twice, because when she come back they do some more repairs.... In my country the situation is definitely better. This is an essential requirement for Arabic men: if he does not enjoy sexual intercourse with his wife, he can't have any relationships outside marriage. Maybe he will marry again and the family will be destroyed. We do not have open relationships like those in European countries (Kawther).*

While the women had different views on the normality of care in the UK, they all affirmed the importance of education during childbirth. The women's perspectives about antenatal classes are examined in the following subtheme, which deals with education.

### **6.6.3 Education**

One of the differences between the two maternity services was the availability of antenatal classes. These were a normal part of maternity care in the UK but such classes are not available in Arab countries. The problem was that not all the women knew what antenatal classes were, and some knew of them but received no invitation. This may be due to language difficulties or because of the view of some midwives that Muslim women did not like to attend antenatal classes:

*I have no idea about that. No one informed me and I never heard about it (Hadeel).*

*No, they did not tell me anything (Kawther).*

*The midwife did not tell me about that or send me a letter. I asked every Arab woman who delivered here about her experience, and they told me about it. When I went to the hospital I asked the nurse there to show me the delivery room, and where to go if I got contractions. She gave me an appointment to see it and I went with my husband. I am sure that these classes teach you many useful things, [and] if you forget that during the delivery your husband will remind you (Fatima).*

Some of the multipara Arabic Muslim women did not like to attend these classes. They said they already knew about labour:

*But I did not register because I already knew about the breathing exercises (Rahma).*

Some women emphasised the difficulty for Muslim women in attending these classes because they were mixed sex. The Muslim women's modesty did not allow them to perform the exercises during the classes.

*I heard that there is concern about education during pregnancy, and I waited for these classes. I am afraid of the labour, and the classes will decrease my fear. My husband is also interested in attending the classes. He came with me every time the midwife visited. The problem is that these classes are for couples and I feel shy about doing any exercises in front of males. I will listen but I won't do any exercises. (Hiba).*

*I received a letter about antenatal classes. I don't like to attend these classes, because it is uncomfortable for us as Muslims, as it is women mixed with men. Where is my privacy with these men, how will I demonstrate the exercises in front of them? I can't do this, I am not used to this. (Zahra).*

On the contrary, other women found there was no problem with mixed classes with their husbands attending. Their husbands accompanied them and both engaged in the exercises, his presence making her comfortable and eliminating her shyness:

*.... I was with my husband and each woman was with hers. If my husband was with me there was no problem - I did not feel ashamed. The presence of the husband is important: he must share with you, and learn how to deal with the new situation. (Amina).*

The other women who attend these classes were happy and satisfied. They described how it helped them during labour:

*In antenatal class they demonstrated [a particular technique] to us for contractions: my husband was to put his hands on my lower back and massage [it] and I was to move to the right and left, like dancing. This move helped me and we did it during delivery (Amal).*

Moreover, the husbands' awareness increased with these classes, and they started to care more for their wives after attending them:

*During my first pregnancy they gave me information. I went every Thursday with my husband. It was useful. I like to go when I am pregnant this time, but I am going to deliver and no one told me anything. With the first baby my husband helped me. He learned how I had to sit during contractions and what I have to do. It was fantastic. He also learned to change the baby's nappies and bathe him. I never asked him to do that and I have no experience; he helped me without my asking him. ... I really liked to attend the classes again (Amina).*

A further aspect of care which was particularly strange for women in this study related to the difference between the two maternity services was the perspective on blood. The women found it strange to deal normally with blood, which is considered profane in Islam. This is discussed further in the following subtheme regarding strangeness of care.

#### ***6.6.4 The Strangeness of Care***

In the women's own cultures, it was unusual to let the husband attend the delivery and cut the umbilical cord. Some of the women and their husbands were scared of the sight of blood. In



fact, some women refused to hold the baby immediately after giving birth to it because it was still covered in blood:

*The midwife told him to come and see the baby's head but he was afraid to see and he refused to cut the umbilical cord. He told me that he was feeling dizzy from seeing the blood (Fatima).*

*They also asked me to hold the baby and breastfeed him but I told them to take him away [because] I was tired and afraid of the blood on him; the sight of the blood caused my blood to run cold (Kawther).*

Some of women felt strange that the baby was not washed immediately after delivery, as is the custom in their own countries. The women felt disgusted by the blood on the baby, which deprived them of the experience of hugging or kissing their child until the following day:

*His smell was not nice; I couldn't come near him or kiss him. They do not wash the baby here. In Jordan, they wash it immediately after delivery... I asked her to wash. She said that they would [not] bathe him [for] 24 hours, until he had adapted to the new environment, and that this layer covering him was useful. I was annoyed by his smell (Hadeel).*

*Perhaps, because the sight of the blood scared me, I was not disgusted by him but I was scared to hold him. I thought the blood might make him too slippery to hold after I delivered him, and because of that I refused to hold him.... (Kawther).*

Others felt that their baby was clean after delivery and they were happy to have it near them. They had positive memories of the smell:

*I put her on my chest. I was so happy the baby was clean, not covered with blood as I thought. I wrapped her in a towel and they kept her with me. They did not give her a bath for 24 hours so as to keep her warm (Rahma).*

*For me it's OK. I was not disgusted by the baby. On the contrary, I thought her smell was delightful. For the first week when I saw, held, or thought of the baby I smelt the*

*same smell. This smell was connected in my mind with the baby. I went home three hours after delivery but I washed her after 24 hours, as they [did here (Amal)].*

Some Arabic women did not allow their husbands to attend their delivery because they were afraid that if the husband saw the large amount of the blood discharged it would cause problems between them. Blood is perceived in Islam as impure. Muslim women cannot pray, fast or touch the Qur'an during menstrual periods and after delivering until they have been cleansed of blood. During these two periods, Islamic law also forbids sexual intercourse. These beliefs reinforce the perception that blood is profane, and therefore that it is not good for husbands to see their wives in such a state of impurity:

*.... it is part of our culture that the husband must see the wife dressed and clean, and can't see the blood because it is profane.... the baby was clean, not covered with blood as I thought.... If the husband saw the wife deliver, the sight of the blood would form a barrier between them, and this would affect the relationship adversely. I decided beforehand not to let him attend the delivery. I like the privacy. Even after the delivery I changed all my clothes and let the nurse change all the bedclothes before he entered the room. Sometimes in the home, if I want to go to toilet and there is blood in bed sheet I will change it immediately - I can't let him see the blood. This is also mentioned by our Prophet Mohammed: one of his friends came and complained that he saw his wife during delivery and [so] he couldn't have any contact with her again (Rahma).*

Despite highlighting the differences between the model of midwifery care adopted in the UK compared to Arab countries, the women did highlight many positive aspects to the care they received in this country. Overall, they perceived that their experiences of childbirth in the UK were not all bad.

## **6.7 The Valuable Experience**

In contrast to the issues of concern highlighted in the previous section, this section discusses the positive aspects of women's encounters with the maternity system in the UK. The women

did narrate in detail positive memories, relating specifically to the value they placed on the midwife, the value they placed on maternity care overall and descriptions of some of their positive experiences.

### ***6.7.1 Valuing the Midwife***

Most of the women pointed out that the midwives met them with smiles. This relieved the women's apprehensiveness and made them more relaxed:

*The advantage here is that midwives are good-humoured and set your mind at ease. They smile at you all the time and make jokes; they are always looking and laughing, and this is a comfort (Amal).*

*She was wonderful. Her way of talking, her treatment of me, and how she greeted me all made me happy. The nice thing here is that the staff are always smiling (Fatima).*

The next quote reinforces the idea that the key to the success of any interpersonal relationship is to put yourself in the other's position, and try to understand and respond to that person according to the circumstances. Amina gave a very interesting comparison between two midwives. The first one made an effort to understand her, which affected her positively, while, the other treated her merely as "part of the job", without giving her the attention due to a fellow human being:

*There were two midwives. One was English and helped me a lot. She always tried to understand me. She offered an interpreter. I felt comfortable with her; she always smiled at me and spent more time with me. The other midwife was Indian. She did things quickly, talking in a high voice; she only wanted to finish her work. She never smiled at me. There was a big difference between the two midwives: I felt secure with the first one. She made an effort to understand and help me. I liked to be examined by her (Amina).*

One important part of the midwife's role is to create a good relationship with her patient, which enhances the woman's trust of the midwife. The formation of such a relationship was described by Hiba and Rahma:

*The midwife was cooperative and answered my questions. She reassured me, and explained everything to me before she did it.... The second midwife was friendlier with me. She talked more, opened various subjects and let me talk. This is better for the pregnant woman's confidence. Here there is no one to talk with, so you find someone to talk with about your pregnancy. It would be difficult if they only give short answers to your questions (Hiba).*

*The midwife was wonderful. She said: "It is a privilege for me to deliver you", and told me how much she loved her job. She told me about her family. She was so nice to me (Rahma).*

The women felt secure and safe during childbirth as a result of the reassurance they received from the midwives. This greatly increased the women's confidence, not only during delivery but throughout the pregnancy. The midwives facial expressions were particularly important for those women with poor English skills:

*She told me, "The time is now five to five. It would be helpful for us if you could deliver at five". I felt relaxed when she said only five minutes, not fifteen or thirty. She wanted me to deliver on the hour. I was scared and tense, [but] when she said "only five minutes," I felt relaxed. She was cooperative about the delivery position.... Her facial expression made me feel secure. She was relaxed, and this affected me positively. She [i.e. her manner] was soothing, (Kawther).*

The participants also acknowledged the physical support from the midwives. The women saw any physical touching during care in a positive light:

*The midwife was wonderful. She talked very pleasantly indeed to me and smiled at me, and this attitude raised my spirits. After she finished the delivery she came and hugged and kissed me (Fatima).*

*The midwife was compassionate. She hugged and kissed me after the delivery (Rahma).*

Another aspect of care referred to by women in the study was the issue of consent. The participants agreed that the midwives always sought the woman's permission regarding the various aspects of her care:

*On the last visit one midwife came and said, "There is a student whose exam is next week. Can she examine you?" I said, "Yes, let me help her." I felt that they appreciated this and took good care of me (Fatima).*

*In every follow up visit there would be students with them and they asked my permission to keep the student in the examination room. I was so happy that this kind of respect was shown when dealing with me (Kawther).*

They also regarded the fact that they were kept informed about the progress of their labour as a valuable aspect of their care:

*Actually I felt secure with her... she was always positive. She said to me, "You're progressing well, everything is OK with you, and there's not much left to go." She encouraged me a lot. I was so lucky that she delivered my baby (Rahma).*

*I was happy when I heard her tell my husband that everything looked fine, and that the cervix was dilated. When she told me, "You can do it", she encouraged me a lot (Kawther).*

The women very often felt they were effectively involved in all decisions about their care, and that they were given options:

*In my country they explain the situation and then they make a decision by saying that this must happen, while here they leave you feel free to make the decision yourself. They do not force you in any direction. They respect your decision because this is your life (Kawther).*

The women felt assured that they were well prepared for giving birth and taking care of the baby after delivery. They highlighted the importance of the information they received, and

pointed out that the midwives were willing to answer their questions and explain things to them in detail:

*When I couldn't understand, I told the midwife and she explained it to me again more simply. I felt that the midwife wanted me to understand everything related to my case. Before doing any tests, she always explained to me why she was doing them, and about the medicine I would take. I knew why they did all the tests they did on me. I didn't feel that they did anything to me that I didn't know about. The midwife didn't hesitate to explain to me in detail (Hadeel).*

Another issue in which the women appreciated the midwives was their awareness of Arabic Muslim beliefs. The women asserted that not all the healthcare providers in the UK were insensitive or prejudiced. Many women described staff who were aware of Muslim women's beliefs:

*I feel that they respected this a lot. When they visited me the first time, they asked me if they had to take off their shoes. It seems they know about our praying. During each visit they assured me that I would be examined by a female. They are aware of these variations between two cultures (Rahma).*

This attention to religious beliefs was reflected in the women being given the opportunity to perform religious ceremonies:

*I was praying during delivery, sometimes in a high voice. The midwife understood that: she never interrupted me. She knew that this was a private matter and kept away. In fact, she was happy about that; she is a well-mannered person and respects what others believe. For example, when she explained to me about the gas you will feel yourself as drunk, I said for her this is forbidden in our religious and she apologised for that. You felt the respect to believers here (Rahma).*

On many occasions the women discussed how staff in hospitals already had a notion of the privacy issue and of the need for female doctors for Muslim women:

*The nice thing was that they understood that I am a Muslim. As soon as I told them I didn't want a male doctor to examine me, they accepted this. I was always examined by a female doctor or midwife. Once I had a scan and there was a male with the midwife training there. When I told her I was a Muslim she understood and asked him to leave the room. They are really considerate about this (Hadeel).*

*I asked to be seen by female staff only. When I was bleeding the male doctor came and stayed at the door until he asked permission from me and my husband to examine me. I was in a serious condition and I had to preserve my life, so I and my husband permitted him to do his work (Kawther).*

In the hospital the women performed their cultural practices and the healthcare providers cooperated with them regarding this:

*They were understanding about this. I do not feel that any healthcare providers disparaged my wearing of the veil. When I was in hospital I had many visitors. This is a cultural issue with Arabs. Everyone has to visit you in hospital and bring food for you. The hospital does not object to huge numbers of visitors or the food, which they cooked and brought for me (Hadeel).*

The women told how they valued some aspects of the maternity services in the UK that were absent in Arab countries, these being postnatal visits and the equitable standard of care. The following subtheme explores this in greater detail.

### **7.7.2 Valuing the Service**

Giving birth in a new country required the woman to seek information on how to take care of her new baby. This knowledge is normally imparted through a woman's family. A migrant woman, however, has to rely on other sources. In this study the women valued the home visits provided for them during their postnatal periods. They noted that these services were not available in Arab countries, and they considered it an advantage of UK maternity services:

*The care after discharge is better here. It is intensive care. They explain more about the baby, the position of sleeping, and that it is necessary to cover the baby with many layers. Next day the midwife came, the day after the doctor came to examine the baby, and then another midwife came after two days, and came back after two days. There were six or seven visits in the first ten days. They take care of baby in an incredible way.... They always came and asked me if I had any complaints, and how the baby was – if he slept and breastfed well – and checked [my] stitches. It was fantastic that they take care of the woman when she gets back home. It was a privilege [to be treated so well]. I hope it will be like this in Jordan.... The midwife came four times, the GP came once, and the health visitors came four times, all in the first three months, which I feel was enough for me. Each visitor stayed around fifteen minutes. They answered all my questions, and if they didn't know, they sent me a letter afterwards [giving me the answer]. I was reassured that they came rather than my having to take the baby and go to the clinic. I felt that they were concerned and that their commitment was high at this point. (Rahma).*

The women were happy that they got their knowledge from staff in authority, and this made them more confident in taking care of their babies. In their own countries, on the other hand, they obtained this knowledge from experienced older women in the family:

*The home visits helped me. I had many questions about the baby and they helped me in this matter. In Syria they depend on the experience of the older women for answering their questions, while here I took advice from experts regarding this. In Syria you receive advice only from women who had had experience of this, [but] here they are experts and have scientific grounds for the information they give you (Amal).*

The women were satisfied with the amount of time staff spent with them answering their questions. Moreover, in the postnatal visits they were concerned not only about the woman's physical condition but also with her mental state:

*They spent enough time with me answering my questions. They asked me if I was happy and could adjust to the new baby. It was nice that they supported me in this way.... They asked if I felt comfortable and happy. I was pleased that they asked. I felt that they were concerned for me. They were really attentive in their work. (Amal).*



All the women asserted that the health visitor was more useful and obliging than the midwife:

*She was not in a hurry. She came and sat with me for one or two hours and talked with me. Frankly she was so useful. ... The health visitor really was more use to me than the midwife was. She gave me much information about how to deal with the baby and how to increase the amount of bottle milk, and she talked with me because I was annoyed about not breastfeeding my baby. She was concerned about my psychological state. She told my mother to go out with the baby.... She always sat and talked with me and we became friends. Next year she plans to visit the pyramids at Giza (Hiba).*

*The health visitor was of more use than the midwife. She cooperated with me more and gave me the address of the clinic where I could give my son vaccinations, and if we asked her about anything she didn't know, she would not ignore it but would call us later to [i.e. when she had found an] answer (Kawther).*

Another aspect of UK maternity services the women valued was the equitable standard of care. The interviewees stressed that all women had free maternity care services in the UK irrespective of their situation. In Arab countries, good quality care is only available to those who can afford to pay for it:

*Treatment is free here, while in Egypt I paid a lot of money for the checkups and scans. Here the standard of care is the same for everyone, while in Egypt you [only] get a high standard of care if you have money (Hiba).*

*In my own country there is care with money. In all Arab countries, if you pay well, you will have a good standard of care. Here they respect human beings. They treat all people at same level, and they are fair in treatment (Zahra).*

### 6.7.3 Positive Experience

At the end of the interviews, the participants talked through their feelings about their whole experience of childbirth in the UK. Despite the difficulties they faced, they valued several aspects of this experience:

*.... it is totally different. I wished before [i.e. in my country] to cuddle my baby and put her in my lap immediately after delivery, but I couldn't. I couldn't put my feeling her into words. In my country I would be anaesthetised, and would stay [in hospital for] one day, tired and dizzy, with a hoarse voice. Here my voice was high [i.e. normal], like how I'm talking with you now, during and after delivery. After I finished delivery I was normal, just a little tired, but there I felt as if I had just been in a battle, exhausted and fatigued... ...I became more attached to this baby. I feel a mother's love as soon as I hold her (Rahma).*

*In my first pregnancy I was nervous about the delivery because I had heard about stitching, and how they [i.e. the nurses] dilate the woman ['s cervix] with their hands. Thanks God that here they leave the woman to deliver normally without interfering. Frankly my experience [here] was wonderful. I had no difficulties (Amal).*

The women who suffered during their childbirth did acknowledge other aspects of the experience, such as the husband's involvement in their care and the kindness of the midwife's treatment that helped them to forget what had happened:

*I felt it was nice to deliver and have your husband beside you throughout the labour and after delivery. His feeling was totally different toward this baby than [towards] our son... Despite this experience's difficulties, I may repeat it. The midwife was wonderful. The problem was with the one who stitched me and with her mistreatment [of me] (Fatima).*

Even with serious complications during pregnancy, the women mainly were happy with the experience in general:

*It was good. I suffered during it, [but] thank God it ended safely. It is normal to face difficulties. As it was my first time, I didn't know anything... I can't criticise their treatment of me. They were nice, and they tried to explain to me everything regarding my treatment. I did not feel any discrimination because of the fact that I am a Muslim and a veiled woman. In general it was good (Hadeel).*

Some women discovered that they played an important role in their childbirth experience. They learned how to act in order to guarantee a satisfying experience next time:

*I think that next time I will do exactly what they tell me. I did not do any of the exercises. It will be more useful and my body would surely be better than this. There were many benefits [here]. They were always giving me booklets that explained everything. If I read them, the experience was easier for me. My delivery was difficult but I think I will forget that. At the time, I said that I would not do it again, but now I think I will deliver here again. When my baby laughs I forget everything. The pregnancy was the easiest and best stage in my childbirth experience. The delivery was the hardest, but in the end you enjoy this difficulty when you see the baby (Hiba).*

## **6.8 Conclusion**

This chapter presented the data as a thematic analysis of the childbirth experience of migrant Arab Muslim women in the UK. An ontological description of what it means to be in such a position was provided. The title of this chapter, “Childbirth experience in an unfamiliar world”, encapsulates many aspects of the women’s experience of childbirth. They told how they prioritised their nuclear families over their extended ones. They then gave a vivid picture of the practices and beliefs they performed during pregnancy, birth and postpartum. They articulated the challenge posed to them by their attempts to access alien maternity services in the UK and the alternative strategies the women used to adapt in their new world were explored. In addition, their experiences made them aware of the dissonance between two very different models of maternity care. Finally, the women talked about the positive aspects of

their experiences. This ontological description used quotes from the women's stories to reveal how they expressed their experiences'

Chapter Seven will summarise the key findings of this thesis and discuss these in the context of existing literature on migrant women and childbirth experiences. The chapter will also discuss the implications of the thesis for research and for midwifery practice.

## **CHAPTER SEVEN**

### **DISCUSSION AND CONCLUSION**

#### **7.1 Introduction**

The purpose of this study was to explore what it means for migrant Arab Muslim women to give birth in the UK, and to widen the knowledge and understanding of the meaning they ascribe to this experience. The research question asked was: What does it mean to be a migrant Arab Muslim woman experiencing childbirth in the UK? An Heideggerian hermeneutic phenomenological approach (1927/1962) was adopted. To ensure the rigour of this research study an intimate relationship between the researcher's interpretation and the data revealed by the women's experiences was maintained throughout the study, and was preserved by continuously revisiting the interview transcripts during the analysis and writing of this chapter.

This chapter discusses the results of the study by comparing and contrasting the findings with the existing body of literature, and outlines the original contribution the thesis makes to that body of work. The chapter begins with a discussion of the main findings of the study. This includes the important socio-psychological changes that occur as a result of migration, women's experiences of childbirth in the UK, and the comparisons they made with maternity care in their home countries. The implications of the study's findings for clinical midwifery practice will then be discussed, and suggestions for further research will be outlined. The limitations of the study are also addressed.

#### **7.2 Overview of Findings**

The participants in this study described their experiences of being migrant Arab Muslim women within the context of their experiences of giving birth, which included their decision to migrate, their pregnancies and deliveries and their postpartum periods. They also

recollected the details of their everyday lives in their own countries, and their traditional beliefs and practices regarding childbirth.

A thematic analysis of participants' childbirth experiences was presented in Chapter Six. Six main themes emerged from the interviews: displacement and reformation of the self; by the grace of God; the vulnerable woman; adaptation to the new culture; dissonance between two maternity health systems and the valuable experience. These themes reflected the women's lived experiences of their childbirth in the UK. The themes present a contextual background to the essence of the phenomenon. A meaningful phenomenological description of the research question was demonstrated and the participants revealed the essence of meaning of their experience of childbirth in a new world.

Overall, these Arab Muslim women regarded their migrant status mainly as a challenge, bringing back both positive and negative memories, although they all expressed gratitude to God for giving them the strength to get them through the period of childbirth with all its vicissitudes.

This study draws attention to the social and psychological changes that occur in the lives of migrant women. The migration process is stressful for both male and female migrants. The cultural transition involved placed additional demands on women to relocate themselves into a new setting and to find new and satisfactory ways to interact with their husbands and children. The concept "socio-psychological transition" explains the changes in women's inner selves in their new settings, taking into account changes in gender roles, family dynamics, cultural conflicts and the alternative strategies they adopt in order to create harmony in their new lives in the host society.

### **7.3 The Socio-Psychological Transition of Migrant Woman**

This study focuses holistically on the women's experiences in the UK in order to enhance an understanding of accessing maternity services in a wider social and cultural context. The study uniquely addresses what it means for a migrant woman to remove herself from the domination of her extended family to live only with her nuclear family, what this new life

teaches her and how this impacts on her maternity experience. Previous research has primarily dealt with the challenges migrant and minority ethnic women experience during childbirth (Katbamna 2000, Small et al 2002, Richens 2003, Ny et al 2007) rather than providing a detailed interpretation of what it means to be thrown into an alien world whilst pregnant. This study goes far beyond the difficulties facing migrant Arab Muslim women in accessing maternity services to give a fuller picture of their lives before migration, the subsequent changes in their identities as migrant women and the impact of this on experiences of childbirth.

The women in this study experienced a great change in their sense of self, of being-in-the-world - 'their new world', and they began to construct new self-images that differed from those in their previous existences. The data revealed that the women started realizing their value as wives and mothers when they were removed from their extended families, and especially so as regards the increased affection between husband and wife. Moreover, the women reported feelings of self-reliance, without the necessity of seeking help from other females. A significant aspect also discussed was that of the women's self-determination; the freedom to decide their own way of life. Finally but no less important, the women were more relaxed in their new worlds without the interference of their extended families. The women acknowledged that these feelings were linked to their displacement from their normal worlds, "the life in their own countries before migration", and their immersion in an alien world, "their lives in the UK after migration". These results constituted one of the original contributions of this work.

The women in the present study described how the UK's lifestyle offered women freedom through a nuclear family structure. Because this structure did not involve the distraction involved in caring for other members of the extended family, it became central to their world. They could live and raise their children as they wanted to, without reference to the wishes of their extended families. Women with children found that their lives were more relaxed, and that the children were more obedient to their mothers as a result of freedom from interference in their upbringing by extended family members.

The findings highlighted that migration created a "new" woman able to live confidently in a new world. These findings correspond to a number of other studies carried out with employed migrant women. Hernandez-Albujar (2004) reported that after Latin American women settled

in America and adapted to their new lives, their family roles changed: they started sharing power, decision-making and responsibility with their husbands. Darvishpour (2002) found that Iranian families in Sweden changed from patriarchal (i.e. traditional) to more egalitarian power structures, and that the women achieved independence and power within this democratic society. Likewise, Nepalese migrant women asserted that they became independent and shared in decision making (Rolls and Chamberlain, 2004). The women were glad not to have to obey their mothers-in-law any longer. Through employment, Nepalese women discovered a sense of belonging and self-worth, and found that they enjoyed being autonomous. In this study, similar experiences are expressed by women not in employment; all study participants were housewives, whereas other studies have investigated the socio-psychological changes of financially independent women

Seungsook (2003), by contrast, found that the changing power relationships between the migrant husband and wife may adversely affect their lives. He found that the contribution to the family income made by Korean women living in the United States was not sufficient to ensure a greater egalitarianism. His findings showed that economic and social changes as a result of migration threatened family stability. High levels of tension between the Korean couples often resulted because the husband embedded in a traditional family structure reinforced gender inequality in marriage by strengthening the husband's position. The Korean family structure resembles the Arabic family structure in association with conservative gender ideology, characterized by the husband's control over the wife on the basis of his role as the sole family provider. Migration, with the decline of traditional patriarchal structure, affords women the opportunity to alter domestic gender relations. They may renegotiate their power and request a more equal share in decision making and housework from their husbands. The modern patriarchal structure in the UK allowed Arabic Muslim women in the present study to achieve more egalitarian conjugal relations.

A number of studies have examined the influence of migration on the relationship between mothers and their children. Such findings highlight how women perceive themselves in the context of their role as mothers. Hernandez-Albujar (2004) found that, after Latin American mothers settled in Italy, they built better ties with their children than in their countries of origin because of the improvement in their socioeconomic conditions. This positive relationship made mothers more emotionally stable, happy and relaxed, which in turn positively affected their interaction with their children. In Liamputtong's (2006) study of



Cambodian, Lao and Vietnamese women in Australia, the women maintained that becoming mothers enabled them to become responsible for themselves, a responsibility that gave them a sense of self-worth, as well as making them more mature as they went through a process of personal growth and development and became less self-centered. On the other hand, the women worried about being bad mothers because of the long hours they had to spend doing physically demanding work. The women in the present study also reported a sense of self-worth when they were given the chance to raise their children without interference from other members of their extended families. This responsibility, with the consequent freedom to act on their own initiative, positively affected the mother-child relationship: the women felt more attached to their nuclear families in their new surroundings. This finding confirms those of a previous study by Karimi (1997), who asked Egyptian women who had migrated to the UK if their lives had altered. Forty seven per cent testified to great changes: they claimed to have become more independent, with fewer social constraints, and these changes entailed extra responsibilities and rights. However half of those questioned also found the social life in Egypt better because of the family support, and because they were emotionally more secure.

The study also showed that the experience of childbirth in an unfamiliar world raised questions and concerns regarding some women's beliefs and practices, when they must cope with life in a new setting. The women also maintained that the most troubling aspect of this experience in an alien world was the loss of social support.

Sharts-Hopko's (1995) study of American women having babies in Japan provides valuable insights into some of the cross-cultural experiences of American women in a Japanese context. She asserted that childbearing in a cross-cultural context is a stressful experience. Some of the issues she raised in her paper are mirrored in this research project. These issues included the expectations of the host culture versus the woman's own cultural expectation; a point also raised by Meleis (1991) who highlight issues such as isolation from the family, the need for affirmation, and the need for social support.

## **7.4 Being A Family Living in A Different Culture**

The women in their new lives started adopting new strategies for the purpose of co-existing with their new environment as harmoniously as possible. These strategies were relevant to the

main theme, entitled “Adaptation to a new culture”. This theme revealed what it meant for women to be part of a family living in a different culture.

The study also shows that giving birth in an unfamiliar world obliged women in new surroundings to disregard some of their traditional customs and adapt their behaviour to their new life. The women did assert, however, that they could not ignore their religious beliefs. If they understood something to be God’s command, they had to obey it.

One major advantage to the participants in the present study was the existence of the autonomous nuclear family model. This model obliges the husband to cross cultural boundaries and adopt a non-traditional role, participating in his wife’s care during the period surrounding childbirth. While, in Arab culture, childbirth is regarded as a female domain; the husband is not expected to participate in his wife’s care. The loss of female support networks upon emigration creates a space for a husband to assume some marital and parental responsibility. The majority of women in this study saw their husbands as supporters during their pregnancies and deliveries, support they viewed as essential to enable them to manage childbirth as migrants. The majority of the women reported positive feelings at the prospect of their spouses entering their spheres, a change that brought benefits to the husband-wife relationship as well as the attachment between father and child. Others, however, felt uncomfortable and even ashamed that their husbands demeaned themselves in this way. For them, cooking and housework was counter to masculinity.

In this study I have endeavoured to shed light on basic questions regarding changes in the traditional husband’s role in their new world. This study also highlights many new and positive aspects of the husband-wife relationship, in the light of the woman’s experience of emigration and subsequent childbirth. Living in the UK entails a move from traditionalism to modernisation for the couple, which lessens the exclusively feminine characteristics of childbirth; although in some cases the couple may still adhere to this tradition. The role of the midwife in this situation is to discuss with the woman the benefit of her husband’s involvement in her care, and to try to encourage the husband to participate in that care. It is certainly not to stereotype the husband’s adherence to cultural practices as ignorance and indifference.

The view of husband's support by women participating in this study was similar to the findings of Ny et al (2007), whose study explored the experiences of Middle Eastern women accessing maternity services in Sweden, and in particular the involvement of their husbands. The women characterised the participation of their husbands positively: the prospect of the husband's adoption of a role that is traditionally feminine gave him the opportunity to witness his wife's tribulations during delivery, and enhanced his attachment to the new baby.

The findings of the present study also concur with recent research into Somali women's experience of giving birth in Sweden (Wiklund et al, 2006). The study indicated that both Somali women and men recognised that they were breaking with tradition when men participated in their wives' care. This had both negative and positive effects on their relationship. Some women were happy to share the experience of giving birth with their husbands, and the men were at once interested and deeply affected, but other couples felt sharing the experience of delivery to be uncomfortable and embarrassing. The same study found that relationships between couples became closer and more loving, being characterised by a greater unity and interdependence and a better capacity for solving problems that arose between them, which is goes in the same line with the findings of this study.

Involving the husband in a woman's care, came from the absence of their support network, their consequent social isolation and their longing to be with their families. Without exception, the women found the isolation they experienced in the UK extremely unpleasant and uncomfortable, in particular as regards feelings of loneliness, helplessness and alienation after the loss of their social support network. Longing for family and homesickness were common to them all, feelings that grew more intense in the postpartum period: they longed for the support they would have received in their own countries. Those women whose husbands were unsupportive reported feelings of sadness, tension and depression. The women's difficulties were aggravated because they came from cultures where women are nurtured, supported, appreciated and helped during childbirth. After emigrating, however, they became socially isolated in their new settings, dealing with alien maternity health services and unable to practice some of their familiar traditional customs. Some of the new mothers described the difficulties involved in the transition to motherhood in a new country, because of the absence of a female social network. These findings are supported by Wiklund et al's (2006) study in which Somali women complained that childbirth was arduous and stressful in Sweden without help from other female family members, so that they had to

manage by themselves. They also felt lonely and alienated. Barclay and Kent (1998, P6) argued that “the transition from ‘woman’ to ‘mother’ is a major one and it can be hugely stressful when combined with the transition from ‘local’ to ‘immigrant’. Recognition of the complexity of being a new mother in a new country will hopefully lead to greater understanding of early mothering for non English speaking background women”.

Some of the women in the present study reported feeling unhappy, lonely, exhausted and confused after delivering. This may have been due to their social context: they felt poorly prepared for the experience of childbirth far from their families. They were in need of practical help and emotional support. As Rahma said, “I need the touch of [my] mother”. At this point, I would add my personal reflection as an Arab woman who has given birth in Arab countries and worked in maternity services there. I have found the rate of postnatal depression to be less in these countries than in Western ones. The participants in the present study agreed that it is rare to hear of postnatal depression in Arab countries. The prevailing culture there recognises delivery as a special time and celebrates it, emphasising the care of the new mother. Participants in this study described postpartum rituals intended to promote the mother’s mental health: emphasising her appearance, including encouraging the use of makeup, styling her hair and buying new clothes in advance in order to celebrate the baby with the huge number of well-wishers later in the postpartum period. During this period, the new mother stays in bed, her sole responsibility being to breastfeed the baby. She is constantly being visited by other people who come to share her happiness in her newborn child. She has no opportunity to be lonely and sad. These findings are supported by Hoang (2009) who found that social support during confinement in Asian culture is designed to maintain the mental and physical wellbeing of the new mother.

After emigration, the new, socially isolated mother is deprived of this traditional postpartum care. She is discharged from hospital and goes to a home bereft of mother and sisters to help her and the baby. The situation is made worse if the husband is not able to take care of the wife, either because of long working hours or because the influence of the culture in which he has been raised, with its disapproval of male participation in the care of a mother and child, is too strong. Stern and Kruckman (1983) maintain that postnatal depression is a Western phenomenon and a “culture-bound syndrome” (p 1039), a conclusion they came to after studying the mental well-being of new mothers in the context of their societies, comparing

those in which the predominant culture pays attention to the new mother's physical and emotional needs in the postpartum period with those that do not regard this time as special.

The midwife must be aware that the migrant Arab Muslim new mother may be more vulnerable to postnatal depression than other new mothers because of the accustomed and crucial role of social support in preserving their emotional stability. Midwives must also eschew the use of the term "depression" because it reflects a lack of faith in Muslim society: there is a stigma attached to such a diagnosis (Sheikh and Gatrad 2008). Most Arab Muslim women believe that the transition to motherhood must proceed smoothly, with religious belief in God's will. If the mother shows any signs of an inability to cope, she is labelled a "bad" mother (Nahas et al 1999). A diagnosis of "depression" is frowned upon because of its longer term personal and social implications. It is better to use "misery" instead of "depression" when dealing with this group of women, because that term implies a normal response to the demands of the postpartum period, such as breastfeeding and sleeplessness. Depression, on the other hand, is seen in Arab society as a psychiatric illness, which is highly stigmatised in Arab culture. This may also in part explain why the phenomenon is not well recognised in this group of women as it may be hidden from view within the family.

Although there are changes in the sense of the self, and family dynamic there are also some key aspects of Arab Muslim culture, which remain of key importance to migrant women during childbirth. Traditional values and beliefs greatly affect women's experiences of childbirth. One of the difficulties facing the women in this study was the cultural insensitivity of healthcare providers. It is therefore necessary to discuss traditional beliefs and practices concerning childbirth in the context of the women's own perspectives. This discussion is of considerable value to maternity caregivers who wish to deliver culturally competent care to such women.

## **4.5 Arab Muslim Customs Regarding Childbirth**

The perception of "By Grace of God" also emerged as a theme in this study: the women described the pervading impact of religion on traditional Arabic practices concerning childbirth. The perception of childbirth in Arab Muslim society is as a sacred process. The women told how they saw childbirth as a gift from God, a view that shed light in several

ways upon the obligation this imposed on them. In Arab Muslim societies, this results in the great care taken of mothers and their babies

The migrant women in this study highlighted the need for retaining some religious duties and traditional cultural beliefs in their new world, asserting the importance of bearing children in compliance with religious law and traditional beliefs relating to childbirth.

Particular practices permeated all the women's experiences, and decisively influenced the meaning they ascribed to them. In this study interviews revealed one of these practices as the extensive attention paid to a childbearing woman in Arab countries by the females around her. The purpose of this physical and psychological support is to safeguard the woman and the unborn child. She is advised to eat a correct diet during pregnancy and the postpartum period, a diet based on the "hot" and "cold" diet model, and to have enough rest, all so as to avoid a miscarriage. There is great concern shown for the women's psychological state at such times. They are made to relax, and bad news is kept from them as much as possible; the husband is obliged to avoid causing her any stress. Arabs believe that everything in the mother's body is transmitted to the baby during pregnancy, and that after delivery anything detrimental will affect the amount and quality of her breast milk. New mothers are also required to enhance their beauty after delivery. Before delivery, they ensure that their looks will not suffer afterwards. The interviewees described how all they did after giving birth was to lie in bed in full makeup and style their hair. Well-wishers would visit them to celebrate, and the other females in the family did the cleaning and cooking and looked after the other children. The women's responsibility in the postpartum period was to breastfeed their babies and to maintain a positive outlook.

The data revealed women's strong belief in God's will. Arab Muslim woman must be content with what God has ordained for her. She must only thank Allah for everything and trust in him. The women in the study did not like to have antenatal screening tests performed just in order to find out about their unborn children. Arab Muslim parents have no right to electively terminate pregnancies. The participants also highlighted the distinction between the sexes in Arabic societies, stressing that this view is a cultural one and has nothing to do with religion. They explained their use of natural methods to space their pregnancies, because of the cultural and religious importance of having children. This consequently limits the use of modern contraceptive methods in Arab Muslim societies.

The data reveals Arab Muslims' perceptions of labour to be intensely religious. They believe that women are cleansed of all their sins after delivery. They read the Qur'an during labour, and pray confident in the expectation of a response. The data also revealed how Arabic Muslim women neglect their own interests at the expense of their children. This was evident in three areas: in order to stay as long as possible with their children they endure labour pain at home, only going to hospital a few hours before delivery; they pressed to be discharged as soon as possible; and they make every effort to breastfeed their children in spite of all difficulties they face. The women in the study testified how both Arab culture and Islam inspire breastfeeding. This attitude obliges women to breastfeed in order to be considered good mothers.

The discussion of Arab Muslim childbirth customs is for the first time discussed in the context of the influence of religion. Moreover, no previous studies have discussed these customs regarding pregnancy, birth and the postpartum period in such a deeply interpretative way. Other studies that have been conducted in the UK explore the childbirth beliefs and practices of minority ethnic women whose socioeconomic status was quite different to that of the Arab Muslim women who constituted the subject of the present work (Richens 2003, Pollock 2005).

Maternity caregivers should be aware of the importance of observing the childbirth customs of Arab Muslim woman. They should endeavour to create a trusting relationship with the childbearing woman that values their social, cultural and spiritual context.

The women maintained that Arabic nutritional habits demand the increase of food intake and a concentration on the quality of the food. Kridli (2002) supports this in her description of how pregnant women in Arab countries pay special attention to their diet and rest. For example, they are encouraged to eat well, to rest often and avoid strenuous work. A study of the strategies practiced during pregnancy by female Somali emigrants to Sweden described a tradition of reducing food intake in order to prevent fetal growth, ease labour and avoid the risk of caesarean sections. This finding differed from those of this study. But the fact that female genital mutilation is widespread in Somali society must be taken into account, which may explain why women follow this strategy. The literature also shows that Indian women practice caloric restriction during pregnancy (Essen et al 2000).

The present study highlights the need for a 'proper' diet during childbirth period for maintaining good health. The interviewees' dietary beliefs were based on the concept of balancing 'hot' and 'cold' foods and restoring the equilibrium of the body's temperature. The literature contains many examples of this belief worldwide, from places as diverse as India, Thailand, China, Korea, Bangladesh and Malaysia (Howard and Berbiglia 1997, Katbamna 2000, Liamputtong 2000, Brathwaite and Williams 2004, Ariff and Beng 2006).

This study made it clear that Arab Muslim women came to the UK with a rich heritage of beliefs and practices concerning childbirth. Traditionally, these women observed many postpartum customs in order to ensure good health after birth and in old age. For example, participants described how confined women must keep their bodies warm by not taking full showers and wearing long-sleeved clothes. Also they must follow dietary precautions such as consuming hot food, because after giving birth their bodies are viewed as being in a cold state. These traditional customs are also common in Southeast Asian cultures, being known as "mother roasting". Liamputtong (2000) described a Thai postpartum ritual called *yu fai*, which required the new mother to lie on a wooden bed over a warm fire for the first month after birth in order to restore the heat lost in labour. In Chinese culture the new mother is expected to stay at home during her confinement, which usually lasts for one month. She must regulate her diet according to the philosophy of yin and yang, and not consume foods that have cold properties. She must keep her body warm and not take full showers, and she must keep her hair dry (Brathwaite and Williams 2004). Ariff and Beng (2006) highlight these same traditional practices are followed in Malaysian society, and they suggest such practices are in fact common in many Eastern cultures.

The participants also complained of different Arab and Western notions of childbirth concerning diet, rest and baby care. They all discussed how breastfeeding is encouraged on religious and cultural grounds in Arab countries, and how all women looked forward to breastfeeding, hoping to continue it for two years. This result was echoed in one comparative study conducted in Israel, in which every one of the Arabic women decided to breastfeed their babies, while 71 per cent of Jewish women expressed their interest (Rassin et al 2009). In the UK, breastfeeding rates are below the international average; the UK is still considered to have a lower uptake of breastfeeding than other European countries (Lavender et al 2005).



The results of a study conducted in a teaching hospital in the Northwest of England showed that “support” was an important factor in breast-feeding. Women reported that physical and emotional support from family, healthcare providers and peers can increase the duration of breastfeeding (Lavender et al 2005). In Arab countries new mothers receive significant emotional and physical support during and after childbirth, as has already been mentioned. It could be that this is the principal reason for the success of breastfeeding among Arab women. From my own perspective as such a woman, I grew up learning that the new mother’s main function is to successfully breastfeed. I constantly heard women who had breastfed talking about how magical it felt. Then I experienced it myself, and was happy and satisfied that I could breastfeed my children for two years. I feel the way all Arabic girls are brought up in this way plays a positive role in their future breastfeeding success. Rassin et al (2009) have the same view, noting that Arab women breastfeed more and longer because they were raised in a society where breastfeeding is the common rule and therefore they breastfeed more. In contrast, they found Jewish society viewed breastfeeding as optional and not as a culturally embedded rule. Hence, a Jewish woman who chooses not to breastfeed is not an exception and will not be regarded a lesser mother (Rassin et al 2009, p129).

The data revealed how Arab Muslim people believed in acts of God. They believed in predestination, and they accept their destiny without demur. God will choose what is best for them. Allah created everything and knows the fate of all things. What is good and evil has been decreed by God. The same conclusions were reached by Khalaf and Callister (1997), who reported the low use of birth control methods in Jordan. This is because such methods are seen in Arab Muslim culture as a lack of faith in God’s will. Ghazal-Aswad et al (2001) explored the knowledge and practice of contraception among women in the United Arab Emirates. They found that sociocultural traditions, religious beliefs and poor knowledge influence decisions to use contraceptive methods. The participants in the present study believed that the ethical objective of marriage is procreation. Contraceptive methods should therefore only be used to space pregnancies rather than prevent them. Ghazal-Aswad et al’s study revealed a widespread employment of natural contraceptive methods among these societies, because of the great influence of religion and culture on contraceptive use.

The women in this research refused to go for such screening tests as Down’s syndrome, as indeed did those in Rassin et al’s (2009) study. Both revealed lower frequencies of genetic examination among Arab women.

The findings demonstrated how these women sacrificed themselves for their children after giving birth to them. Thai women who participated in Liamputtong's (2006) study suggested that a good mother must sacrifice herself for her children, and fulfil her obligations to the best of her ability. Such a view is supported in this study, with Arab Muslim participants who went to hospital a short time before delivery because they wanted to stay longer in the home with their children and tolerated the labour pain. Also, they insisted a few hours after delivery to be discharged for the same reason.

The women participating in the study valued their babies the same way, irrespective of gender. However, they discussed the contradictory view of Arabic culture which makes a distinction between the sexes, with a preference shown toward sons, as only boys enlarge the family and continue the family line. Boys keep the family name and pass that name on to their sons, which preserves the honour of the family. Some of the women wanted a baby boy to please their husbands and their families in law, not for their own preferences. Kridli (2002) mentions that Arab cultures prefer sons because they provide economic and physical support for the family and that Arab women are expected to continue to bear children until they give birth to at least one son.

This section has provided a broad overview of traditional Arabic childbirth beliefs. Discussion of these beliefs and practices may help maternity caregivers to integrate them into their care plans. Maternity care professionals need more understanding and awareness of the beliefs concerning childbirth held by Muslim women in general and Arab Muslim women in particular. This will enhance the provision of high-quality maternity care and the building of trusting relationships with such women.

Many women may wish to observe childbirth, pregnancy and postpartum practices which conflict with the advice given by health providers. Examples concern rest, physical exercise and recommended food intake. Midwives must therefore encourage women to talk about their expectations regarding pregnancy and childbirth and the cultural and religious values related to these, as well as ensuring that her wishes are observed during her care. Explanations should be provided as to why any particular practices cannot be accommodated. To further reduce dissatisfaction it is the midwife's role to ensure that appropriate information is provided and that expectations of antenatal care and birthing experiences are realistic. One of

the issues midwives must take into account in order to ensure cultural competent care is food, which may be prescribed or prohibited for religious or cultural reasons irrespective of health, or specifically for childbearing women during their pregnancies and after childbirth. These commands may relate to basic foodstuffs including meat, fruit and vegetables. Midwives should discuss appropriate diets with each of their clients according to how they view hot and cold foods at this stage. They should also consider any dietary considerations.

This study has also revealed the experiences of Arab Muslim women as they accessed maternity services in the UK. The following sections briefly summarize these findings and discuss how these experiences relate to the body of literature which explores the maternity healthcare needs of those women who belong to ethnic minority populations in the UK. The study highlights difficulties and challenges in delivering a high quality of maternity service for Arab Muslim women.

## **7.6 Negative Experiences of Childbirth in the UK**

This study explored the challenges of childbirth from the perspectives of migrant women. As chapters five and six have shown, the women participating in this study identified the main challenges involved as difficulties in language and communication, poor cultural awareness among staff, discrimination and racism, midwives' dispassionate behaviour, and uncomfortable stays in postpartum wards.

Some women complained of language isolation during their childbirth. They asserted that a good level of communication allowed them a greater feeling of security when delivering in a foreign country with a different language. Those who were not confident English speakers overcame this challenge by using their husbands as interpreters, but they encountered other problems such as the husband withholding bad news or a reluctance to ask the midwife certain types of question. On the other hand, the women were happy with the midwives' methods of delivering information during labour. In the main, the women agreed that they had enough information during their childbirth. The problem was the absence of bilingual information.

The study revealed how some women experienced racism at the hands of some healthcare providers, which increased their suffering and affected them deeply. Some of them told of the problems caused by their Islamic style of clothing. Some women also reported that they were prejudged by some midwives as being demanding, and complaining. They recounted their suffering under the routine of the maternity system, as well as complaining of some midwives' emotional coldness.

Other challenges revealed by the study were the cultural differences between the Arab Muslim tradition and the practices of caregivers in the UK. These included the confirmation of pregnancy, the perception of childbirth as normal rather than special or extraordinary, and the "rooming-in" policy. The majority of the women perceived little attention was paid to mothers during the period of childbirth. Expectant mothers were not advised to take any precautions during their pregnancies, and after delivery they received minimal institutional care. The philosophy of maternity care in the UK is that motherhood is a natural, undemanding process, and there is an expectation that all women should be able to deal with the new role. However, Arab Muslim culture sees childbirth as a major life event, exacerbated by vulnerability. The present findings also highlighted the difficulty of the postpartum hospital stay for these Arab Muslim women, who suffered because of the food, the shared room and the toilet facilities. They did not have the right quality and quantity of food, enough rest and any privacy.

An important issue arising from the data was the difficulty of characterising a particular issue in Arab society as either cultural or religious because they overlap to a significant degree. One example concerns Arab women's preference for female doctors. The data revealed that the issue of male doctors emerged as a potential challenge for Arab Muslim women, some of whom demanded to be examined by a female doctor. In Islam, the saving of life is paramount, so there is no religious prohibition on women being examined by a male doctor. Refusal is culturally determined – but this in itself is conditioned by religious considerations, because Islamic teaching includes a requirement for Muslim women to cover their bodies and wear the hijab. This modesty is culturally reinforced to the extent that refusal to let any male other than members of their immediate families see their bodies is also applied to medical practice. In this case, culture has made a relatively adaptable religious requirement so comprehensive and inflexible that some women find it difficult to adapt their behaviour when they find themselves in a different context.

The findings of the present study broadly confirm evidence from others. Katbamna (2000) found that Bangladeshi women did not receive full antenatal care due to the unavailability of female doctors. Ali and Burchett (2004) reported that most Muslim women feel intensely embarrassed and uncomfortable at being treated by male health care providers in the UK. The study also showed how women feel disempowered when their request for female doctors was ignored, and they were forced to accept a male doctor because no other choices were offered them. Another study investigated Lebanese women's responses to the medical management of their pregnancy and delivery in Lebanon. The women preferred female obstetricians, attributing their preference both to modesty in the presence of males and to feeling at ease when discussing personal matters with a female doctor. In addition, they expressed feelings of shyness and discomfort when being treated by male doctors (Kabakian-Khasholian et al 2000).

In this study interviews revealed that childbearing Arab Muslim women preserved their modesty during antenatal appointments, labour, postnatally and when breastfeeding. Hammoud et al (2005) state that Arab Muslim women preferred caregivers to knock before entering their rooms to give them times to cover their body and hair. In fact, the women did not expose their bodies if it was not necessary. Most Arab Muslim women also prefer to breastfeed their babies in private.

The challenges experienced by this group of women were in some respects unique. The participants in this study were middle class, well educated, accompanied by educated husbands and were free from financial problems, even though they experienced many difficulties. These women are representative of those societies, namely Arab Muslim ones that have suffered from more racism in Western countries after 9/11 and the London bombings. In particular, the potential discrimination they could be faced with in maternity services in the UK in the current climate has never been investigated.

These findings do however, show some similarities with previous research which has explored the childbirth experiences of ethnic minority women in the UK, that have identified a range of barriers to the delivery of high-quality care. Four categories emerged from previous studies: the shortage of accessible information, insufficient interpretation services for non-English speaking women, the discontinuity of care and the consequent feelings of not

being in control of events, and cultural insensitivity and stereotyping (Harper-Bulman and McCourt 2002, Mcleish 2002, Richens 2003, Bharj 2007). In a wide range of studies, language barriers were identified as a fundamental barrier to the delivery of effective maternity care (Katbamna 2000, Harper-Bulman and McCourt 2002).

Studies that have investigated the viewpoints of women from minority populations of maternity care highlighted many important elements, including support from caregivers, the provision of information and the use of understandable language, racism and discrimination, and the empowerment of their choices regarding various aspects of childbirth (Essen et al 2000, Harper-Bulman & McCourt 2002, McLeish 2002, D'Souza and Garcia 2004). Bharj and Salway (2008) highlight the desire of all childbearing women of minority ethnic origin for accurate and easily understood information about childbirth, to the same level as British women. The women in the present study affirmed the importance of easily understandable and accessible information, bilingual booklets and good communication support

The Somali women in a study by Essen et al (2000) said that they had not been informed about various kinds of painkillers during their labour in Sweden, nor could they recall any new information given them during their antenatal follow-up care. These findings contradict those of the present study, in which the interviewees were happy with the information and the choices given them in the UK, although they did highlight the language barrier when communicating with midwives as an occasional problem. They all said that the midwives discussed pain relief methods with them and gave them choices. The women in the present study also testified that, with the help of their husbands to act as interpreters, they were given adequate information and choices regarding their childbirth.

The women in this study did emphasise the necessity for the provision of translated materials. Katbamna et al (2000) proposes that the availability of bilingual health information can eliminate language barriers, avoid unnecessary suffering and lessen the expenses involved in healthcare. It is suggested such bilingual materials are written in simple English and include pictures and diagrams in order to improve the access of health services by minority ethnic groups (Mir 2007).

The findings of the present study broadly confirm evidence from others. Katbamna (2000) finds that Bangladeshi women do not receive full antenatal care due to the unavailability of

female doctors, communication problems and their reliance on their husbands to escort them to the clinic, with the attendant difficulties faced by those husbands in taking time off work for this purpose. In this study the women were aware of the unavailability of female doctors and tried to adopt an alternative strategy to overcome this challenge, also they discussed the difficulties of having the husband as interpreter during their care.

Some of the women in the present study complained that they were ignored and were labelled and prejudged by some midwives because of their appearance of colour. This lack of respect in their treatment epitomised their feelings of alienation. Kridli's (2002) examination of the attitudes of Arab American women undergoing labour found that this group expected caregivers to stay with them in the delivery room, that they would be made to feel secure and they would receive all the help and attention they needed. This attitude may be misinterpreted by healthcare professionals, who label them as "demanding". A review of papers published between 1966 and 2002 concerning disparities in reproductive health outcomes found bias, prejudice and stereotyping by healthcare professionals toward ethnic minority populations (Anachebe 2003).

Some women in this study saw healthcare providers as kind, helpful and well mannered. This health professional attribute enhanced their childbirth experience. On the other hand, all the women were unhappy during their stay in post-partum wards: they felt uncomfortable with the food and the shared rooms and toilets. A comparative qualitative study assessing maternity care of Pakistani and white British women conducted in a northern UK NHS region noted similar negative comments about hospital stays during antenatal and postnatal periods. Both groups, however, commented positively on postnatal community care (Hirst and Hewison, 2001). Despite the congenial midwifery, the results reveal the unpleasant surroundings in postpartum wards which made the women apprehensive and uncomfortable and insistent on going home. This is similar to the experiences of women in the general population. A survey conducted by the National Childbirth Trust (NCT) shows that 49 per cent of women have no real privacy on a postnatal ward because staff and visitors enter rooms without knocking. The women also attributed their negative experience of childbirth to shared toilets and shortages of birth aids (NCT, 2005). In the context of the Muslim women in this study, dissatisfaction with privacy levels may have been enhanced by a wish to cover themselves.

This study offers insights into women's views of the attitudes and abilities of midwives. Many women appreciated their treatment, supportiveness and kindness while others felt negatively toward midwives, feelings that impacted on their experiences of childbirth. They maintained that some midwives were unsympathetic and ethnically insensitive. These results are in line with those of the participants in Bharj's (2007) study; viewpoints exhibited a similar dichotomy between positive and negative comments regarding caregivers' attributes and attitudes.

In her book *Safer Childbirth* (1998), Tew recounts that many years after giving birth women remember the details, especially the positive and negative aspects of their relationships with their care providers. Proctor and Wright's (1998) study of women's responses to maternity services identifies staff attitudes, especially midwives' supportiveness and helpfulness, as a key element in women's satisfaction with the service as a whole. The main sources of negative comment in Proctor and Wright's study were the paucity of information, a deficiency in the explanations provided, and a lack of reassurance about their progress. Many comments indicated poor communication between health professionals and the women. They also mentioned other aspects of the services that bothered them, such as cleanliness, noise levels, food and privacy in postpartum wards. This shows the similarity of experience of minority ethnic and white women. Most of the women in the present study complained about the care in postpartum ward, and how the services were insensitive to Muslim beliefs regarding the issues of food, privacy, and caregivers' treatment.

## **7.7 Positive Experiences of Childbirth in the UK**

Findings indicated that many midwives created a trusting relationship with the women, which relieved their apprehension. This reassurance enabled them to feel secure and safe during childbirth. They also acknowledged the physical support they received, as well as the reassurance given by the midwives' facial expressions. Another aspect that they appreciated was that of consent. Many women also agreed that they were kept informed of the progress of their labour, and that the midwives were willing to answer their questions and explain matters to them in detail. The most satisfactory aspect of their experience was the home visits during the postnatal period, a service that is not available in Arab countries. The study revealed that



the women were happy with the amount of time staff spent with them answering their questions during postnatal visits. Finally, some demonstrated that the women themselves also played a crucial role in their unsatisfactory experiences of childbirth, and that they learned many lessons from these experiences regarding how they should act next time in order to guarantee satisfaction.

The study showed how important it was for migrant childbearing women to be greeted with smiles and treated in a friendly fashion by caregivers, not in a consumer-provider relationship. The study gave midwives the key to the creation of trusting relationships with migrant woman, a key that involves simple acts such as smiling and touching. This is the first study that presents the situation vividly, not only in theory but from the women's own viewpoint. It was the valid view of real women who have lived these experiences. The women's positive recollections mostly regarded midwives' attributes, thus encouraging other midwives to follow suit and thus be forever remembered as the wonderful people migrants encountered in a tough period of their lives. This emotional description given by the women is considered to be an original contribution of this study, not hitherto discussed in this way.

The need for culturally competent maternity care has been demonstrated in a project called "Migrant-Friendly Hospitals" which was conducted in Europe to assess the needs of immigrant women and to develop ethno-culturally sensitive material and training courses to enhance maternity healthcare (Karl-Trummer et al 2006) . Two hospitals in Austria and Italy were involved in this project and they implemented a training course for pregnant women from ethnic minority backgrounds. The course focused on four dimensions: access, information, sensitivity to literacy levels and support of facilitators. The findings showed that women made positive comments regarding all dimensions and that their knowledge was enhanced by the training. The women felt that they were well-informed and provided with sensitive care concerning their personal needs and cultural backgrounds (Karl-Trummer et al 2006). This project reinforces the need for culturally competent care for migrant women, and shows how this improves the quality of care they receive, which was one of the Arab Muslim women's complaints in the present study. Effective midwifery care necessitates understanding of the migration experience in the context of its physical and emotional consequences on childbearing migrant woman, by addressing cultural, social, economical and linguistic barriers. Providing culturally competent care requires respecting the traditional family structure, gender roles, family support system and community services. Downs et al

(1997) added, "The establishment of a sustained partnership with clients, based on the support of protective traditional health practices and the recognition that a women is expert in her own health" (Downs et al 1997 p499). In this way, culturally competent midwifery care could better serve the population of migrant women.

## **7.8 Comparison between the Two Maternity Services**

After discussing the positive and negative aspects of their experiences of childbirth, the participants elaborated on the differences in those experiences between UK maternity services and those in Arab countries. They stressed that they had to interact with an unfamiliar maternity health system. Many matters arose, such as the dissonance between the two systems, a finding that conflicts with those of similar studies. The women were used to a high level of medical intervention when they gave birth in their own countries, and were astonished by the natural birth procedures in the UK.

This study clearly showed that there are obvious differences between maternity services in the UK and in Arab countries. The study pointed to four aspects in particular: midwifery instead of obstetric care; the use of drugs and supplements during pregnancy and labour; the limited number of scans, and episiotomy and cosmetic suturing.

Few studies up to the present have examined the differences between the two maternity services, and none have addressed the differences in the context of moving from a medicalised childbirth system to a more natural one. They have only explored the views of those women who came to a more advanced maternity system, and how they appreciated the care in that system (Rolls and Chamberlain 2004). This is the first study that has explored the views of migrant Arab Muslim women experiencing a more natural maternity system and how this influenced their perception of care.

One of the women's complaints was the insufficient number of scans during pregnancy. In the UK the first scan is routinely done in the twelfth week of gestation. There is, however, good evidence that current ultrasound technology can distinguish between normal and abnormal pregnancies in the first trimester. A positive pregnancy test does not always mean an intrauterine pregnancy (Sadek and Sciutz 1995). Transvaginal ultrasounds show foetal

heart action in normal pregnancies at around 37 days from the first day of the last menstrual period. If the ultrasound shows an empty uterus, no adnexal mass, the pregnancy could be ectopic, the dates could be inaccurate or there could be a complete miscarriage (Morin and Van den Hof 2005). Transvaginal ultrasounds in conjunction with quantitative-HCGs can diagnose ectopic pregnancies. An early scan to confirm that the baby is in the womb can have a dramatic effect, If an ectopic pregnancy is diagnosed before the tube ruptures, keyhole surgery or drug treatment can be used, which will promote quicker recovery and increase the woman's chances of maintaining her fertility. A delay in diagnosis may endanger the life of the woman. Between 2003 and 2005 there were 32,100 ectopic pregnancies in the UK resulting in ten maternal deaths. These women died as a result of a failure to diagnosis their ectopic pregnancies (CEMACH 2007). Early ultrasounds enable an accurate diagnosis of tubal pregnancies, making it possible for management to be more proactive. These data underline the importance of conducting the first scan for pregnant woman before the twelfth week of gestation in order to reassure the woman that her pregnancy is normal, as revealed by my study.

The philosophy of the maternity services in the UK views labour as normal, and adopts an approach towards care that allows the woman to deliver without technology and medical intervention (Gould 2000). A successful delivery in UK terms would imply no intervention, and a natural birth. No other studies have compared the style of maternity care in Arab countries on the one hand and the UK on the other.

Lennart Righard, a senior pediatrician in Sweden, defines natural birth as a birth exclusive of medical intervention. She argues that if the woman is given freedom of movement in a calm environment during the first stage, and if she performs relaxation techniques in that stage and between pushes in the second, there will be no need to use drugs. She stresses that if the woman is relaxed and confident, labour seems very easy. She highlights that the problem with healthcare providers is that they complicate the physiological process by unnecessary medical interventions (Righard 2001). One of the unnecessary medical interventions is epidurals to decrease or eliminate contraction pain. Dr Walsh argued that labour pain stimulates the release of endorphins which help women to adjust the pain. Moreover, epidurals decelerate labour contractions and increase the need for hormone treatment to accelerate the contractions. There is also a correlation between epidural administration and an increase in the rate of instrumental delivery to complete birth successfully (Walsh 2009).

Some of the women in this study complained that, because they were not screaming from the pain of the contractions, they were regarded as not needing painkillers. Midwives must be aware that the expression of pain may be culturally determined. Failure to groan or cry out, grimace or thrash does not mean that a woman is free from pain. Labour pains are articulated and managed differently according to cultural background. Available options for pain relief must be explained and discussed in advance if possible, women asked about their preferences regarding pain relief and other sources of comfort, and alternative pain relief methods such as massage and relaxation techniques considered. In the case of massage, care should be taken to enquire as to whether certain parts of the body must be avoided.

Some of the study's participants, especially those women who had given birth in Arab countries previously, stressed the importance of cosmetic stitching, which tightens the vagina. This was regarded as essential for Arab women in order to satisfy their husbands sexually, thereby preventing them from divorcing them and remarrying. Some women found it necessary for this stitching to be done at the time of childbirth rather than enduring the additional pain and expense of having it seen to when they returned home, but all participants did hold it to be indispensable sooner or later. This desire would be seen by someone from a Western background as evidence of the oppression of Arab women by their patriarchal societies, so that it is always them who makes sacrifices and endure pain in order to keep their husbands contented. It was not the intention of this study to judge Arab culture in this regard, but rather to understand the meaning of the childbirth experience of Arab Muslim women. Midwives naturally use self-reflection as a means of dealing with religious and cultural diversity. This practice could pose problems, however; if this is based on stereotypical perspectives, it may prevent midwives developing their knowledge of some cultures and of understanding the fact that their clients have culturally and religiously conditioned needs, rather than coming from inferior cultures and therefore needing to change their behaviours. Midwives should be aware of the women's concerns and explain sensitively why this is not a practice that is routinely offered in the NHS. Midwives must accept women as they are, without adding challenges in an already stressful period. Change and acculturation will come in time by continuous education and the creation of trusting relationships. Midwives' responsibility when dealing with women from other ethnic backgrounds is to increase their knowledge and skills with regard to culturally competent care, as argued by Reitmanova and Gustafson (2008, p.109), who maintain that "a care

provider who acquires such knowledge is thought to express greater tolerance and appreciation for the values and world views held by Muslim women”.

Some of the women complained about the vaginal/perineal tears they suffered after labour, and questioned why the midwives did not perform episiotomies. Research evidence suggests that routine episiotomy is no longer required to prevent third degree tears and may in fact cause them (Myers-Helfgott and Helfgott 1999). The women in this study thought that natural childbirth in the UK caused tears; three participants in this study suffered second degree tears. In Arab countries, episiotomies are carried out routinely and justified on the grounds of tear prevention. It became evident from many considerations that it was necessary for midwives to take the time to discuss the model of care and its benefits with the women in their charge. If women are informed beforehand about such things as the conditions of labour, the reasons why only two scans are carried out and the use of drugs is limited, they will place much greater trust in the maternity services in the UK – or at the very least, the level of dissatisfaction will be decreased.

Another important element mentioned by those women who had experienced labour in Arab countries was that they were deprived of early breastfeeding because of labour analgesia, and they were grateful for the opportunity of early breastfeeding with natural birth in the UK. There was also scientific evidence of the benefit of this practice, besides the speechless nature of the early attachment between mothers and their newborn children. The studies reported that if babies were left to search for and lick their mothers’ nipples by their own efforts, their reflexes would begin to function and postpartum maternal oxytocin would be released, which would enhance the separation of the placenta (Matthiesen et al 2001).

One of the differences the study highlighted was that concerning antenatal classes. Those women who took advantage of antenatal classes valued this service. Two women attended these classes were happy and satisfied. They described how it helped them during labour, and how their husbands’ awareness increased with their attendance at these classes. They were not concerned about the presence of men in these classes. The presence of their husbands made them comfortable and eliminated their shyness. However, other women were confronted with two problems concerning antenatal classes. Four women addressed the lack of information regarding these classes. They were not invited to ante-natal classes perhaps due to the stereotypical view of midwives that Muslim women were unlikely to attend. Two

women were invited, but were concerned about the mixing of the sexes in these classes and for this reason they did not take up the invitation. Their modesty would not allow them to perform the exercises during the classes.

Seven out of eight women in the present study were happy to allow their husbands or mothers to accompany them during delivery. They spoke of the support they received from their families and how this helped them persevere with labour. A study of the effect of emotional support of the mother during labour by close friends or relatives showed that such assistance can decrease the number of medical procedures and complications considerably (Medi et al 1999). The support of midwives during labour is also essential. Hodnett defined support during this period as the presence of an empathetic person who offers advice, information, comfort and emotional support to help a woman cope with the stress of labour and birth (Hodnett et al 2002). Recently, continuous support during labour has become the exception rather than the rule in hospitals worldwide. Concerns about the consequent dehumanization of women's birth experiences have led to calls for a return to continuous support by women for women during labour. A Cochrane Review about labour support concludes that continuous support during labour has many benefits including decreased maternal and neonatal morbidity such as caesarean delivery, operative vaginal delivery, use of intrapartum pain relief medication and five minute Apgar scores of less than seven (Hodnett et al 2009).

The women were concerned about the psychological setting in the labour room. They wanted an atmosphere characterised by sympathy, warmth and love. Denis Walsh (2006 p.95) explains why women choose one birth centre over another: they concentrate on the social, personal and environmental aspects of care and tend to downplay or even ignore "risk" and "safety" aspects such as the "absence of doctors, epidural provision, electronic fetal monitoring, facility for obstetric procedures like ventouse or caesarean deliveries, or an ambulance journey of at least 30 minutes if complications arose".

The first antenatal visit is an appropriate time in which to familiarise women with health care practices and services in the UK. There are significant differences between health systems in the UK and in Arabic countries. Women's expectations of health services may be based on totally different systems, understandings that should be explored.

At the commencement of this study, I was disappointed by the idea of natural birth. I believed that technology must be used to assist the woman undergoing labour. After I heard the positive comments of the women who had experienced natural birth and had read about this style of birth and its effects on both mother and child, I changed all my preconceptions and began to understand how much I had lost the exquisite pleasure of engaging immediately with my baby after delivery. All my previous deliveries had left me exhausted because they were induced: I could not bear the labour pains, so I was given analgesic drugs. After 10 to 12 hours of induction I could not see or touch my babies. On the first day, I did not like them, and I was hallucinating and sleeping, which deprived my babies and I of early breastfeeding.

Now I understand that the practice of fixing women in the lithotomy position with their legs raised and resting in stirrups throughout the whole period of labour, which is the policy of Arab maternity units in the second stage of labour, exists for the convenience of care providers, and has no benefit for the labouring woman (Tew 1998). The providers believe that the supine position is essential for the medical procedures they implement during labour, such as applying electronic fetal monitoring, inserting epidural anesthesia and intravenous hydration, and administering drugs to speed the labour up (Tew 1998). They completely ignore the side effects of this position, which benefits only them, namely that it decreases maternal-placental-fetal blood flow and the descend of the presenting part. As a result, the intensity of the contractions are reduced, the cervix is less dilated, the labour lasts longer and the woman asks for more pain relief. Tew (1998, p148) argues that “without the help of gravity, greater force is required to push the burden uphill through an opening now prevented from stretching to accommodate the descending head, which increases the incidence of lumbar strains and perineal tears and creates the need for episiotomy and forceps assistance. Impeding the process in this way adds to its duration, while the dorsal position exposes the important blood vessel, the vena cava, to the pressure of the heavy uterus, impairing the mother’s blood circulation and the oxygen supply to the fetus”.

Practices in Arab countries simply copy twentieth century Western ones; the Arab world has not reflected more recent developments concerning care, and has not recognised that natural birth is safer than medically assisted birth. One study conducted in the UK investigated the effect of interventions during labour and birth outcome for low risk women. The result revealed that the use of epidural and induction of labour for low risk women increased the rates of instrumental delivery with an episiotomy or caesarean section after labour (Roberts et

al 2000). Another Australian study demonstrated the cost of obstetric interventions used during labour for low risk women. The findings showed 50% increased birth cost for primiparous and 36% more cost of birth for multiparous (Tracy and Tracy 2003). Childbearing women in Arabic countries are deprived of less interventionist and safer birth care with the domination of private obstetric care. In our Arabic countries we are urgently in need of less interventionist care and instead, would be better served by continuous and one-to-one midwifery care. This would reduce the unnecessary obstetric care and replace it with community-based midwifery models, which enhance the quality of women's childbirth experiences.

I now believe in the efficacy of natural birth and look forward to experiencing it as a mother. Immediately after finishing my study, I will start giving lectures to midwives in my own country about how to become more active in their roles and not be reduced to obeying obstetricians' instructions. I would like them to have autonomy in caring for low-risk pregnant women rather than just following obstetricians' orders; I would wish that they were as strong-minded as their counterparts in the UK. In this way their status in Arab countries can be raised. My second wish would be to have birth centres in Jordan like those in the UK, centres managed solely by midwives and aimed at providing care for low-risk women during childbirth. It would be beneficial for all future pregnant women and their newborn children to experience natural birth. My intention when I go home will be to lecture and write about the advantages of natural birth and the side effects of the old, mistaken practices followed in Arab countries.

To summarise, the data revealed by this study supports many of the findings of previous research, while building on them to offer a more in-depth, rich description of the experience of migration for pregnant migrant Arab Muslim women. The study also highlights the need for midwives to recognise that contrary to the stereotype of the predominance of natural childbirth in less developed societies, many women in modern Arabic societies (especially those from middle class backgrounds) will expect a highly medicalised and doctor dominated system of maternity care and may be surprised and initially disappointed by a midwife led service which emphasises a de-medicalised approach to childbirth. This requires midwives to provide a sensitive explanation of the different approach in the UK if women are not to feel discriminated against, or dissatisfied with what they may perceive as a lower standard of care.



## **7.9 The Unique Contribution of This Study**

This study opens a number of new dimensions that expand the range of knowledge and understanding of the subject, and bring to light new meanings to the Arab Muslim woman's experience of childbirth in the UK. The aspect of displacement and self-reformation has not previously been discussed for this group of migrants. The sense of being uprooted from a familiar world and thrown into an alien one requires maternity care providers to observe the profound influence of migration on women.

The self-reformation of migrant Arab Muslim women has not previously been discussed in the context of their experience of childbirth in the UK. The nursing and midwifery literature explores the barriers to the achievement of high-quality maternity care (McLeish 2002, Richens 2003), while the social literature investigates self-reformation of employed woman (Seungsook 2003, Hernandez-Albujar 2004) but not the meaning of the new self-image attributed by migrant childbearing women to their experiences of childbirth.

Some of the concerns highlighted by women in this study are shared by women from the majority population. Improving and enhancing dignity, modesty, choice and individualized care is important for the women in this study, but would clearly benefit all women. However, this study's most substantial and unique contribution is the deep ontological description of the childbirth experience of migrant Arab Muslim women in the UK, which has demonstrated the specificity of experience in great detail as well as some commonalities of experience with white women. The study has brought to light a rich ontological understanding and interpretation of the research question by approaching Heidegger's philosophical tenets of Being (1927/1962), which encompasses the essence of the experience and illustrates Dasein, the ontological nature of being (in this case) a childbearing Arab Muslim woman in the UK.

## **7.10 Implications for Practice**

The results of this study include some important issues for considerations for the practice of maternity care. The implications are categorised into four groups concerning recommendations for migrant women and couples, institutions, midwives and community groups.

### ***7.10.1 Implications for Migrant Women and Couples***

- Fluency in English is important if migrant women are to become knowledgeable clients. They must be aware and be encouraged to take English language courses. This will help them develop the ability to engage with their health care providers and enhance their use of the services.
- Social networks of women of similar ethnic background are invaluable for preserving the wellbeing and good health of childbearing women. Such networks may provide linguistic and cultural support as well as facilitating access to community resources.
- The migration process provides new opportunities for Arab men to understand fatherhood in a different way, which they might not have experienced if they had not emigrated. Migrant women need to encourage their husbands to participate in childbirth process by engaging them in the detailed aspects of their childbirth.
- Arab couples should be aware of all procedures surrounding pregnancy and childbirth and be encouraged to attend antenatal classes. This will prepare them for labour and parenthood in their new settings, particularly with the change in family dynamics and the need to take account of a different institutional context for healthcare delivery.

### ***7.10.2 Implications at Institutional Level***

- Provision should be made for effective and continuous training programs on the basis of religion, culture and ethnicity for all care providers, including receptionists, allowing a reflexive approach to developing cultural competence.
- Maternity health services need to be ‘father-friendly’ and produce well-planned strategies to involve the husband in care. For migrant couples, the husband may be the key support for a woman who has lost all her family support. In involving men, services need to be sensitive to the possibility of different gender relations within non-western cultures.

- Health care services should provide accessible information which would facilitate migrant women to better understand the UK healthcare system and the available choices of pain management, such as relaxation techniques, breathing exercises and positioning. Information could be provided in audio-visual and DVD formats as well as written text.
- In planning policies, NHS organisations should take into account the diverse needs of migrant women during childbirth, such as nutrition and modesty requirements, in order to gain women's trust in maternity services.
- The maternity service should show sensitivity towards the religious needs of Muslim women. For example, the majority of Muslim women would prefer women-only antenatal classes to comply with Islamic laws. However, some migrant women may prefer their husbands to be present in order to support them later. The two options of antenatal classes should be available.
- Ideally, the number of trained interpreters for non-English speaking women should be increased. However, the additional cost to the health services may not allow this. As a minimum telephone interpretation should be available for all those with lower proficiency in English. Women should not have to rely on husbands or children for interpretation.
- At institutional levels, service managers should ensure that caregivers are inspired and well prepared to communicate effectively with women from ethnic populations.
- The employment of bi- or multilingual staff may improve the delivery of culturally competent care. Katbamna et al (2000) argues that staff from ethnic minorities can share knowledge about their cultures with colleagues, while eroding cultural stereotyping in services by chatting informally about these communities (Mir, 2007).
- Services should create supportive and protective surroundings for women at risk of racism. Addressing exclusion in services can eliminate stereotyping and improve the quality of care for victims of racism (Karlsen, 2007).

### ***7.10.3 Implications for Midwives***

- Midwives should understand that childbirth occurs in a cultural context, and it is important to appreciate the intensity of the influence this background wields, in order to enhance maternal outcome. Care should be culturally competent and emphasise the importance of recognising differences as well as creating trusting relationships. At the same time, midwives should be aware of the dangers of labelling women because of their cultural and religious beliefs. Midwives should also be aware of the importance of seeing beyond the contexts of religion, cultural and ethnic background to focus on the individual woman.
- This study revealed information about the beliefs and practices of Arab Muslims. Understanding these traditional beliefs will assist midwives in delivering culturally competent care geared to the needs of Arab women, promoting a more positive childbirth experience. Adherence to traditional understandings however, will vary between women. It is therefore important for midwives to discuss with each woman individually the significance of her perceptions of childbirth, assess what is important for the woman to observe during the period of her pregnancy and childbirth and discuss ways in which these needs might be met within the UK system. It is also important for midwives to explain what is not possible within institutional provision in the UK and why, to avoid feelings of disappointment or dissatisfaction.
- Efforts should be made to provide female caregivers when requested by women. If this is not possible, then women should be informed in advance of the possibility that they will be attended to or examined by a male care provider. In such instances, women may request the presence of their husbands, female friends, or other female staff for reassurance.
- Midwives should be particularly aware of the importance of modesty for Muslim women giving birth and ensure that sufficient covering is offered and that modesty is considered at all stages.

#### ***7.10.4 Implications for Local Community Groups and Centres***

- Community centres could provide courses for recent female immigrants on how to integrate into the host society.
- New arrived migrants would benefit greatly from being able to access local groups and by attending orientation events. This would help to decrease woman's isolation, depression and anxiety.
- Recruiting bilingual migrant women volunteers, who have experienced childbirth, to accompany women with limited English skills during antenatal visits and labour may be of benefit.

### **7.11 Implications for Future Research**

Suggestions for further research arising from the present work include the following

- Future studies could attempt to include a greater number of Arab migrant women of varying socio-economic status and educational levels. Research could also include Arab Muslim women who have migrated as refugees or asylum seekers.
- The richness of data produced by this study has allowed a detailed understanding of the childbirth experience. It is important to conduct ethnographic research exploring the childbirth cultures and experiences of other migrant groups. As the UK is considered to be a multicultural country, such research would enable midwives to deliver culturally competent care and would help in developing multicultural maternity care models.
- Research on men and childbirth in the context of migration is extremely limited. This study has shown the importance of considering the role of migrant men. Investigations of the experiences of migrant husbands would greatly add to our

understanding of the impact of migration and the significance of gender relations in childbirth.

- Because of the increased number of migrant families around the world, more research should be done in order to further understand the meaning of being a wife and mother in a foreign country. The women's own perspectives as revealed by this study capture the meaning of the emerging dominance of the nuclear family over the extended family and adapting to life in a new context.
- It would be valuable to carry out further research which follows Arabic Muslim women on their return to their own countries, to explore the potential challenges these women face in going back to their extended family structures and traditional cultures and the impact of their UK experiences on their future lives. Further research could explore to what extent women are able to continue to resist or challenge dominant norms of family life and how the experience of giving birth in the UK might impact a future pregnancies in their home countries.

## **7.12 Limitations of the Study**

Although this study has successfully answered the research question, it is acknowledged that it has some limitations. In Chapter Three, those limitations associated with the phenomenological approach were detailed. As previously discussed, the aim of this study was to explore the childbirth experience of immigrant Arab Muslim women in the UK and to widen the understanding of the meaning attributed by these women to that experience. It was not the intention to provide causal explanations, generalise the findings or generate theory; consequently, the approach used was appropriate to the study's aim.

One further limitation is the small sample size, which may consequently not be representative of Arab Muslim migrant women. However, the argument that this small number of respondents might limit the generalisability of the results is invalid because the study's goal was to gain in-depth descriptions of the data and not to generalise to the wider community. The small sample size does not mean that the study findings may not assist midwives in

understanding some of the issues that some migrant Arab Muslim women may face when experiencing childbirth in the UK. It does, however, re-emphasise the need for midwives to approach women as individuals within a cultural context and ascertain individual interpretations of cultural norms and values.

Another limitation is that all the participants in this study were middle class, without financial problems; none of them were illiterate. The issues arising from the current study may differ from those raised by women with financial and literacy problems. In addition, reasons for entry to the UK for mostly education and women coming to the UK for other reasons, such as those fleeing persecution, are likely to have different needs and experiences.

Finally, the approach used by this study was longitudinal. This obliged the researcher to explore many aspects of the experience to find the phenomenon's ontological meaning. The large amount of data revealed by this approach, to say nothing of the demands imposed by fulfilling the requirements of this thesis, possibly militates against an in-depth exploration of some of the issues raised. Hopefully this can be addressed in subsequent exploration of the data and publication of the study's findings.

## **7.13 Conclusion**

This research study applied Heideggerian hermeneutic phenomenology to reach an understanding of the childbirth experiences of migrant Arab Muslim women in the UK. It is hoped that exploring these experiences will help future childbearing women migrating to this country achieve better maternity care after exploring the positive and negative aspects of their childbirth experiences. The knowledge obtained from this study has revealed some essential issues that health care providers should be aware of when caring for migrant women in general and Muslim women in particular.

The women's strongly differentiated opinions on issues to do with maternity care were related to previous literature. Their positive feedback will assure healthcare providers that their efforts are greatly valued, and will inform policy makers that some aspects of maternity services are delivered to a high standard and are appreciated by migrant women. The negative feedback regarding weaknesses in the delivery of care for Arab migrant women is also useful

to care providers, as is such feedback for health managers concerning the women's own priorities for their care.

This study contains a vital lesson: Arab Muslim women are not a homogenous group, and neither are their experiences of childbirth. Some viewed their experiences positively and others more negatively. Similarly, there was considerable variation in the way women perceived midwives. Some midwives exhibited racism and stereotyping while others were the opposite, making every effort to respect the women and to deliver culturally competent care. The variable experience of midwives had a considerable impact on how women viewed their maternity experience. Some midwives were described as wonderful and caring, while others were seen as unsupportive, all working within the same institutional context. Nothing was assumed about the meanings people attributed to their experiences. Individual experiences are seen differently at different times, in different environments and by people with different backgrounds (Heidegger 1927/1962). The variety of these findings only enriches our understanding of the childbirth experiences of Arab Muslim women and shows the crucial importance of the woman-midwife relationship.

The heterogeneity of childbirth experience for Arab Muslim women stressed the importance for midwives to avoid essentialising Arab Muslim women. This approach ignores individual differences between women and treats women who often come from disparate backgrounds as a homogenous mass. Essentialism also ignores the agency of women. The women in this study acted as active agents to resist, challenge and adapt traditional elements of their culture in their new world. Understanding the fluid and dynamic nature of Arabic culture shows that Arabic women are not passive subjects, submissive to male dictates, and family and community expectations. They were able to adapt to their new lives in many ways.

Midwives practice their profession daily, which presents them with frequent opportunities for reflection on their procedures, for self-criticism and self-appraisal, and thereby for improvement. Taylor argues that all manner of knowledge can be generated through reflection. Midwives can benefit from a range of reflective process in dealing with women from different ethnic backgrounds. This process demands a series of interpretative reflective questions the midwife should ask herself in order to gain more knowledge about the woman she is taking care of: "What do I want to learn through reflection?", "Why do I want to learn it?", "What questions will stimulate and guide my reflections and led me to the answers I am



seeking?” If midwives want to understand themselves, other people and other conditions better, they would be well advised to use a form of interpretive reflection (Taylor), the methodology that underpins this study.

It became clear that the role of delivering high-quality maternity care lies with individualized midwifery care. Midwives must implement a holistic approach that recognises each woman’s uniqueness and focuses on her distinct needs (Gerrish 2000). The midwives indeed required detailed assessments for each woman in order to form a comprehensive picture of her in her social context, this in turn with the aim of providing individualised care. Henley and Schott (1999 p13) said “General information about a patients ethnic group or religion does not tell anything reliable or specific about the real person in front of you or about their needs. But, provided it is reliable and respectful, it can be a framework within which, carefully and sensitively, to ask the right questions”. Good quality maternity care may be achieved by individual midwife identifying the wishes, needs and concerns for each migrant Arab childbearing woman. A culturally respectful and holistic approach by midwives towards Arab Muslim women would reinforce quality care.

My hope in presenting this study is to help maternity caregivers understand Arab Muslim women’s own perspectives on their experiences of childbirth. I hope all care providers will stop and think before delivering care to any migrant women and ask themselves the questions: “How can I put myself in her position?” “How would I wish to be treated myself?” “How can really deliver culturally competent care to this woman?” If my efforts lead to caregivers asking these questions and responding appropriately, I will feel that my study will have some value for migrant women worldwide.

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## **Appendix One: Ethical Approval**

## Appendix Two: Presentation Guide



### Presentation guide

This is a list of points to be presented to women in groups when discussing the project.

- Who am I?
- What is the study called?
- What is it about?
- Why am I conducting the study?
  - PhD
  - Improve care
- Why am I talking to you today?
  - Recruitment
- What the study involves?
  - Interview
  - Telephone contact
  - Checking transcript
- Offer a general invite to participate
- Give to women
  - Information sheet

## Appendix Three: Study Poster in English



# Arab Muslim women's Experiences of Maternity services in The UK

Hand by hand we can improve the quality of maternity services for Arab Muslim  
pregnant women in the UK,  
You can do this by sharing your own experience

Are you a pregnant Arab Muslim Woman?  
Are you interested in participating in the above research project?

If yes please contact:

Hala Bawadi:  
C/O Tina Harris  
De Montfort University  
Hawthorn Building  
The Gateway  
Leicester  
LE1 9BH

Mobile no: 07889258996

Or send her an email ( [hala.bawadi@learner.dmu.ac.uk](mailto:hala.bawadi@learner.dmu.ac.uk) )

Your participation is important and valuable to us. If you are not pregnant but know  
any pregnant Arab Muslim woman,

Please pass this information on to her

Arab Muslim Women's experiences of maternity services in the UK  
Is a PhD project being conducted at De Montfort University, Leicester



## Appendix Four: Study Poster in Arabic



### تجربة النساء العربيات المسلمات مع خدمات الأمومة في بريطانيا

لنعمل يدا بيد لتحسين الخدمات الصحية المقدمة للنساء العربيات المسلمات في بريطانيا

هل أنت امرأة عربية مسلمة حامل؟  
هل عندك رغبة بالمشاركة في موضوع البحث سابق الذكر؟  
إذا رغبت بالمشاركة الرجاء الإتصال مع :  
هالة بوادي

بإشراف Dr Tina Harris  
De Montfort University  
Hawthorn Building  
The Gateway  
Leicester  
LE1 9BH

هاتف: 07889258996

البريد الإلكتروني (hala.bawadi@learner.dmu.ac.uk)

مشاركتك ذات قيمة وأهمية بالنسبة لنا. إذا كنت غير حامل وعلى معرفة بأي امرأة حامل الرجاء مشاركة هذه المعلومات معها.

تجربة النساء العربيات المسلمات في رعاية الأمومة في بريطانيا مشروع رسالة  
دكتورة في جامعة

De Montfort في Leicester

## Appendix Five: Information Sheet in English



### Participant information sheet

#### Study title

Migrant Arab Muslim women's experiences during their childbirth in the UK

#### Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand, why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

#### What is the purpose of the study?

You are being invited to participate in a research project conducted by Hala Bawadi a PhD student within the Faculty of Health and Life Sciences at De Montfort University, Leicester. The purpose of this study is to explore and describe Migrant Arab Muslim women's experiences during their childbirth in the UK to make suggestions on ways to improve maternity services for this group of women.

#### Why I have been invited?

You have been invited because you are a migrant Arab Muslim woman who is pregnant and receiving maternity care in Leicestershire, which is the target population for this study.

#### Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

#### What will happen to me if I take part?

The needs and experiences of Arab Muslim migrant women before, during and after childbirth will be explored by conducting in-depth interviews. Each interview will be audio-taped and will take from 30 minutes to one hour to complete. Women recruited to the study

will be interviewed in their preferred language in their own home or at De Montfort University. Each woman will be interviewed three times. The first interview will take place during the third trimester of pregnancy (28 weeks onwards). The second interview will be conducted 1-2 weeks after the birth of the baby and the final interview will take place 1-3 months after delivery. The first interview will focus on pregnancy experiences, the second on birth experiences and the third on postnatal experiences allowing exploration of all aspects care during childbirth.

### **What are the possible benefits of taking part?**

You may not personally benefit from your participation but you can help us to improve maternity services for other migrant Arab Muslim women in the future.

### **Will what I say in this study be kept confidential?**

All information reviewed and collected will be held in the strictest confidence. Your name will be removed from all materials after each interview and interview material anonymised so that you cannot be identified. The researcher will take the responsibility for transcribe and translate the interviews but sections of translation will be check for accuracy buy another translator after removing your name. If this research is publish, no information will identify you. Moreover, no one will have access to the interview information. Only the researcher and her supervisors will have access to the information provided in the study.

### **What should I do if I want to take part?**

If you are interested in participating in the study, please contact the researcher after taking your time to decide to participate on: 07889258996 or e mail her at (hala.bawadi@learner.dmu.ac.uk)

The researcher then will contact you by phone to answer any questions and arrange for the first interview to take place.

### **What will happen to the results of the research study?**

Once the findings have been established, positive steps will be taken to put research into practice. Copies of the research findings will be distributed locally and nationally so that the health professionals understand and become aware of women's experiences and how they may use the findings to improve maternity services for this group of women.

Publications will include Conference presentation, papers for publication, presentations offered to local maternity services and PhD Thesis.

All participants will also receive a copy of the results in the form of a short paper.

**Who is organising and funding the researcher?**

Hala Bawadi (the researcher) is being funded to complete her PhD studies by the Applied Science Private University in Jordan. A supervisory team led by Tina Harris at De Montfort University are supervising the researcher in completing this study.

**Who has reviewed the study?**

The Ethics Committee of the Faculty of Health and Life Sciences, De Montfort University have reviewed and approved the research proposal for this study including the contents and use of this letter of information and accompanying informed consent form.

**Contact for further information**

If you have any question about the research and your participation, please contact

The researcher: Hala Bawadi

PhD student

C/O Tina Harris

De Montfort University

Hawthorn Building

The Gateway

Leicester

LE1 9BH

Telephone: 07889258996

[hala.bawadi@learner.dmu.ac.uk](mailto:hala.bawadi@learner.dmu.ac.uk)Email:

If you have any complaints about the way this project is being conducted please contact: Dr

Tina Harris

Principal Lecturer in Midwifery

Hawthorn Building

The Gateway

Leicester

LE1 9BH

0116 2577804

If you have any question about your rights as a research participant, contact the Faculty Research Office, Faculty of Health and Life Sciences, De Montfort University on 0116 201 7118.

Thank you for your cooperation.

Yours sincerely,

## Appendix Six: Information Sheet in Arabic



### ورقة معلومات المشاركين

#### عنوان الدراسة

تجربة الولادة لدى النساء العربيات المسلمات المهاجرات في بريطانيا

أنت مدعوة للمشاركة في هذه الدراسة ولكن قبل ان تقرري من الضروري ان تطلعي على اهداف هذه الدراسة. أرجو أن تقرأي هذه المعلومات بتمعن وبإمكانك أن تناقشها مع من تريد. في حال وجود اي غموض بإمكانك الاستفسار من الباحثة. خذي الوقت الكافي لتقرري المشاركة أو عدم المشاركة.

#### ما هو هدف الدراسة؟

أنت مدعوة للمشاركة في بحث تقوم به هالة بوادي طالبة الدكتوراة في لثلية الصحة والعلوم الحياتية في جامعة De Montfort في بريطانيا. تهدف هذه الدراسة التعمق في تجربة النساء العربيات المسلمات أثناء الولادة في بريطانيا لتقديم إقتراحات لتحسين خدمات الأمومة المقدمة لهذه المجموعة من النساء.

#### لماذا وجهت لي الدعوة؟

أني مدعوة لإنك إحدى النساء العربيات المسلمات الواتي يحصلن على الرعاية الصحية خلال فترة الحمل والولادة في مقاطعة ليستر.

#### هل يجب ان أشارك؟

قرار المشاركة يعتمد عليك، اذا اردت المشاركة سوف تعطين هذه المعلومات للإحتفاظ بها ويطلب منك التوقيع على إقرار بالموافقة. بإمكانك ايضا الإنسحاب من الدراسة في أي وقت دون إعطاء اي مبرر، قرار الإنسحاب لن يؤثر على نوعية العناية المقدمة لك.

#### ماذا سوف يحصل لي اذا قررت المشاركة؟

لنستطيع تكوين فكرة مكتملة عن تجربة المرأة العربية المسلمة اثناء فترة الحمل والولادة وما بعد الولادة. سوف نقوم بعمل مقابلات مع النساء. كل مقابلة ستستمر من 30-60 دقيقة وسوف تسجل صوتيا. حسب ما تفضله المشاركة ستكون المقابلة في بيت المشاركة أو جامعة De Montfort وباللغة التي تريد.

كل امرأة سوف تقابل ثلاث مرات، اول مرة في الثلث الأخير من الحمل وسوف تركز المقابلة على تجربة الحمل. والمقابلة الثانية خلال 1-2 اسبوع بعد الولادة وسوف تركز

المقابلة على تجربة الولادة. والمقابلة الثالثة خلال 1-3 شهور بعد الولادة وسوف تركز المقابلة على فترة النفاس. مما يساعدنا على ان نكتشف جميع جوانب الرعاية الصحية التي قدمت للمرأة خلال الحمل والولادة.

### ما هي الفائدة الشخصية من المشاركة؟

ممكن ان الفائدة لن تكون شخصية بالنسبة لك ولكن بمشاركتك بالبحث سوف تساعدني في تحسين خدمات الأمومة في بريطانيا للنساء العربيات المسلمات .

### السرية:-

كافة المعلومات التي ستعطينها للباحثة ستحفظ بسرية تامة، إسمك سيحذف من جميع المقابلات وسوف يستبدل بلسم مستعار. إذا نشر البحث لن تكون هنالك اي معلومة تدل على شخصيتك، ولا يوجد اي شخص ممكن ان يصل الى المعلومات غير الباحثة والمشرقة على البحث.

### ماذا يجب ان اعمل لكي اشارك في هذا البحث؟

إذا كان عندك رغبة بالمشاركة الرجاء الإتصال بالباحثة هالة بوادي على هاتف رقم: 07889258996 او البريد الإلكتروني (hala.bawadi@learner.dmu.ac.uk) . ومن ثم ستقوم الباحثة لاحقاً بالإتصال بك للإجابة على اي استفسار والترتيب لموعد أول مقابلة.

### نتائج البحث:-

- بعد اكتمال الدراسة سنقوم بالخطوات التالية
- ❖ توزيع نسخ من البحث محليا وعالميا لزيادة وعي العاملين في مجال الصحة لتجربة النساء العربيات ويمكن إستعمال هذه النتائج لتحسين رعاية الأمومة المقدمة لهن.
  - ❖ النشر سوف يكون عن طريق تقديم اوراق في مؤتمرات، او نشر اوراق علمية في مجلات .
  - ❖ عقد محاضرات الى الجهات التي تقدم رعاية الأمومة في ليستر.
  - ❖ أخيرا هذا البحث هو رسالة دكتوراة للباحثة.
- جميع المشاركات سوف يحصلن على نسخ عن نتائج هذا البحث.

تقوم هذه الدراسة بدعم من جامعة العلوم التطبيقية الأردنية ويشرف على الباحثة كادر من المدرسين بجامعة De Montfort بقيادة Dr Tina Harris .

لجنة تقييم الابحاث في جامعة De Montfort وافقت على إجراء هذا البحث وجميع محتوى الأوراق التي سوف توزع خلال مرحلة جمع المعلومات.

إذا كان لديك اي سؤال بخصوص المشاركة الرجاء الإتصال على:-

طالبة الدكتوراة: هالة بوادي  
بإشراف: Dr Tina Harris  
De Montfort University  
Hawthorn Building  
The Gateway  
Leicester  
LE1 9BH  
Telephone: 07889258996  
Email: hala.bawadi@learner.dmu.ac.uk

إذا كان لديك أية شكوى بخصوص البحث بإمكانك الإتصال في:

Dr Tina Harris  
Principal lecturer in midwifery  
Hawthorn Building  
The Gateway  
Leicester  
LE1 9BH  
01162577804

في حال وجود أي تسائل عن حقوقك كمشاركة بإمكانك الإتصال على مكتب الأبحاث في  
كلية الصحة والعلوم  
الحياتية في جامعة De Montfort على الرقم: 01162017118 .

شكرا لحسن تعاونكم  
هالة بوادي

## Appendix Seven: Consent Form in English



### Consent Form

#### Migrant Arab Muslim Women's Experience During Their Childbirth in The UK

**Name of Researcher:** Hala Bawadi

**Please initial box**

- ❖ I confirm that I have read and understand the information Sheet for the above study and have had the opportunity to ask questions. ☐
- ❖ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. ☐
- ❖ I agreed to take part in the above study. ☐

**Please tick box**

**Yes**

**No**

- ❖ I agree to the interview being audio tape recorded ☐ ☐
- ❖ I agree to the use of anonymised quotes in publication. ☐ ☐

**Name of participant**

**Date**

**Signature**

**Name of researcher**

**Date**

**Signature**



## Appendix Eight: Consent form in Arabic



### اقرار الموافقة تجربة الولادة للنساء العربيات في بريطانيا

إسم الباحثة: هالة بوادي

التوقيع

☐

اقر انني قرأت واستوعبت ورقة المعلومات المتعلقة بهذه الدراسة وكان لدي الفرصة في طرح الأسئلة التي أريد.

☐

أفهم ان مشاركتي في هذه الدراسة تطوعية، ولي الحق بالانسحاب في اي وقت من غير إعطاء اي مبرر.

☐

أوافق على المشاركة بهذه الدراسة.

لا

نعم

☐☐

أوافق على تسجيل المقابلة صوتيا

☐☐

أوافق على استخدام إسم مستعار بدل إسمي في حالة نشر البحث.

التوقيع

إسم المشاركة

التوقيع

إسم الباحثة

## **Appendix Nine: Antenatal Interview Guide**

### **Interview Guide (Antenatal)**

In keeping with a semi structured approach an interview guide will be used rather than a specific list of questions. This will facilitate exploration of pertinent issues identified prior to data collection whilst also facilitating identification of other issues which each woman may feel are relevant.

Initially the following themes will be used to guide the antenatal interview.

Tell me about your pregnancy experience?

- Experience of living in the UK to date
- Finding out you were pregnant
  - Feelings
  - Concerns/anxieties
- Beliefs about pregnancy and childbirth
- Accessing services when first pregnant
  - Where and how accessed information about services including difficulties and assistance.
  - Booking interview
- Ongoing antenatal care
  - Continuity of care
  - Parent education classes and health education
  - Communication during care experiences
  - Investigations: information received
  - Antenatal visits with midwife/family doctor/ obstetrician
  - Support from family/friends

- Cultural and religious issues relevant to maternity care
  - Exploration of culturally sensitive care and whether needs met during antenatal period
- The differences in maternity services between the UK and your own country
- Demographic data
  - Age?
  - With whom you live in the UK?
  - Occupation of you and your husband?
  - What is the highest level of educational achievement for you and your husband?
  - Number of pregnancies (gestation)
  - Number of live births (parity)
  - Expected date of delivery and weeks gestation at time of interview
  - When, why and how did you migrate to the UK?
  - Country of origin
  - Where born

## **Appendix Ten: Perinatal Interview Guide**

### **Interview Guide (Perinatal)**

In keeping with a semi structured approach an interview guide will be used rather than a specific list of questions. This will facilitate exploration of pertinent issues identified prior to data collection whilst also facilitating identification of other issues which each woman may feel are relevant.

Tell me about your childbirth experience from the point you went into labour?

- Accessing maternity services when went into labour
- Companion during labour and delivery
- Communication during labour
  - Offered any interpreter
  - Who acted as interpreter
  - Effectiveness of communication during labour with health care providers
- Care during labour
  - Pain relief
  - Number of staff involved in care
  - Duration of time spent with her
  - Reassurance from staff (verbal support and non-verbal support)
  - Explanation about all procedures
  - Mobility in labour and choice of position
  - Freedom to practice beliefs during labour
- Baby issues
  - Contact with the baby immediately after delivery
  - Baby stay in hospital nursery or in ward with the mother
  - Breast feeding
- Beliefs about labour and delivery
- The differences of labour process between UK and own country
- Suggestion to improve the care during labour
- Care received in hospital after delivery
- Weeks of gestations at time of birth
- Mode of delivery
- Person who conducted the delivery
  - Doctor /Midwife /Midwifery student
  - Gender
  - Mother choice
  - Did she meet her labour carer before labour

## **Appendix Eleven: Postnatal Interview Guide**

### **Interview Guide (Postnatal)**

In keeping with a semi structured approach an interview guide will be used rather than a specific list of questions. This will facilitate exploration of pertinent issues identified prior to data collection whilst also facilitating identification of other issues which each woman may feel are relevant.

- How many days stay in hospital
- Women's health status after discharge
- Tell me about the care you received while in hospital?
  - Breast feeding
  - Care of umbilical cord
  - Episiotomy care
  - Breast care
  - Baby bathing
  - Handle, settle, and look after the baby
  - Circumcision for male baby
- Tell me about postnatal home visits
  - Frequency
  - Duration
  - Help offered
  - Communication in postnatal visits
  - Contraceptive advice
- Beliefs about postnatal period
- Social support
- Psychological status after delivery
- Any suggestion to improve care postnatal

## Appendix: Twelve: Coding Strip

The screenshot displays the NVivo software interface. The main window shows a document titled "Amal antenatal interview - Document Browser". The document content is in Arabic, discussing a pregnancy experience and the role of a midwife. A coding strip on the right lists various codes, including "Safe pregnancy", "Scans", "Sensitivity to arabic b", "Servant", "Settlement", "Short stay after delivery", "Social support", "Staff attribute", "Suggestions", "Summary of the experience", "Suturing", "Thinking of children", "Trust Arabic doctor", "Uncertainty", "Unconcern", "Unsupportive husband", "Vaginal examination on lab", "Waiting before examined I", "Well wishers", "woman consent", "Woman focused approach", and "Woman privacy". A hierarchical tree diagram on the far right shows the structure of the codes, with "Registration" at the top, followed by "Pregnancy care", "English booklet", "Pregnancy care", "continuity of care", "Midwife attribute", and "Antenatal cl".

Amal antenatal interview - Document Browser

Browser Document Edit View Format Links Coding

Amal Postnatal interview

Normal Times New Roman 12 Blue

nearly six weeks pregnant, I went to GP and he sent me to the midwife. The midwife visited me in the home and took blood and urine samples and asked a lot of questions about heredity and any family diseases, if I had any operations or any diseases, and she filled the file which always I take in my check up visit. Always in my visit they check urine, measure my abdomen, hear my baby's heartbeat and manipulate my abdomen to see how the baby is sitting. In my first visit she gave me many booklets, but all in English, nothing in Arabic, so I had to wait for my husband to be free to translate that for me. But I did not face any difficulty in entering the system. Here you will always be seen by a midwife and sometimes a student with her. I am so happy with the midwife always I seen by her.

If the midwife changed what would your feeling be?

I am happy and feel comfortable because I am seen by the same midwife. Now that she knows me and the details of my pregnancy, I feel more secure with the same midwife, but if she changed I expect that the second one would be like the first one. The advantage here is that midwives are good humoured, they are psychologically comforting. All the time they smile in your face and make jokes always jest and laugh, and this is a comforting thing.

Tell me about antenatal classes.

They send me letters to go and do classes. Maybe this time I will go - until now I could not decide. Last year in my first pregnancy I went and they gave me full information about the hospital and the places for delivery. I choose to deliver in water, but it is only one room. If no one is in it I will use it. They explain everything in detail, from ringing the bell, how to register in reception, if I have contractions when I am walking, what moves I should do and what to bring with me to hospital (for

Amal antenatal interview - Co...

Show: All Nodes, Explorer Style

Scope of coding: Document

- Safe pregnancy
- Scans
- Sensitivity to arabic b
- Servant
- Settlement
- Short stay after delivery
- Social support
- Staff attribute
- Suggestions
- Summary of the experience
- Suturing
- Thinking of children
- Trust Arabic doctor
- Uncertainty
- Unconcern
- Unsupportive husband
- Vaginal examination on lab
- Waiting before examined I
- Well wishers
- woman consent
- Woman focused approach
- Woman privacy

Registration

Pregnancy care

English booklet

Pregnancy care

Registration

continuity of care

Midwife attribute

Antenatal cl

Find

Code UnCode

Working Set

Add Node(s) Remove All

Section: 0 Paragraph: 30 Coding:

In-Vivo Staff attribute Code UnCode Coder

Start 2 Internet ... 2 Windows ... 4 NVivo Pr... Document1 ... Document2 ... Document3 ... untitled - Paint EN 12:19

## Appendix Thirteen: List of Free Nodes

NVivo revision 2.0.163

Licensee: HLS

Project: Nvivo analysis 2 2 2 2

User: Administrator

Date: 16/07/2009 - 02:17:17 ã

### NODE LISTING

Nodes in Set: All Free Nodes

Created: 26/12/2008 - 08:03:04 Õ

Modified: 26/12/2008 - 08:03:04 Õ

Number of Nodes: 105

- 1 Acculturation
- 2 Adaptation
- 3 Antenatal classes
- 4 Antenatal tests
- 5 Anxious
- 6 Arabic man
- 7 Arabic mentality
- 8 Baby bath
- 9 Baby care
- 10 baby sex
- 11 Beliefs during labour
- 12 Beliefs during postpartum
- 13 Beliefs during pregnancy
- 14 Birth spacing with Arab
- 15 Blood
- 16 Breast feeding
- 17 Breastfeeding issue with Arab
- 18 bureaucracy in maternity services
- 19 Care after delivery
- 20 Care in Arabic countries
- 21 Care in postpartum ward
- 22 Celebrating delivery in Arabic count
- 23 Changing husband role
- 24 communication channels
- 25 Communication problem
- 26 Confirming pregnancy
- 27 continuity of care
- 28 Contraceptive methods
- 29 Couple relation
- 30 Cultural differences
- 31 Delivery care
- 32 Discrimination
- 33 Down syndrom test
- 34 English booklet
- 35 Envy
- 36 Extended family
- 37 Feeling after delivery
- 38 Feeling of back home

39	Feeling of pregnancy
40	Feeling toward the baby
41	Female circumcision
42	Female doctor
43	Food
44	Gaining control
45	Giving baby name
46	God in childbirth
47	Happy from delivery
48	Health visitor
49	Home visits
50	Husband as translator
51	Husband attendance the delivery
52	Husband comments on labour
53	Husband support
54	Ignorance
55	Individual care
56	Infertility treatment
57	Information
58	Isolation
59	Labour pain
60	Life in the UK
61	Man authority
62	Man in Arabic countries
63	Medicalization vs normality
64	Midwife attribute
65	Midwifery care
66	Migration advantages
67	Missing family
68	Mixed classes
69	Moment of labour
70	New mother in Arabic country
71	Non adherence to beliefs
72	Onset of labour
73	Pain killer
74	Phone before delivery
75	Physical status of new mother
76	Postpartum depression
77	Pregnancy care
78	Pregnancy complication
79	Presence of the mother
80	Privacy in breastfeeding
81	Recounted story
82	Registration
83	Relocation
84	Safe pregnancy
85	Scans
86	Sensitivity to arabic beliefs
87	Servant
88	Settlement



89	Short stay after delivery
90	Social support
91	Staff attribute
92	Suggestions
93	Summary of the experience
94	Suturing
95	Thinking of children
96	Trust Arabic doctor
97	Uncertainty
98	Unconcern
99	Unsupportive husband
100	Vaginal examination on labour
101	Waiting before examined for labour
102	Well wishers
103	woman consent
104	Woman focused approach of care
105	Woman privacy

## Appendix Fourteen: Tree Nodes Explorer

**Node Explorer - Nvivo analysis 2 2 2 2**

Node Set Tools View

Browse Properties Attributes DocLinks NodeLinks Edit Set Assay Search

**Nodes**

Trees (106)

- Adaptation
  - Changing husband role
  - Life in the UK
  - Migration advantages
  - Well wishers
- living as nuclear family
  - Couple relation
  - Husband comments on labour
- Acculturation
  - Husband attendance the delivery
  - Husband support
- Arabic life
  - Arabic man
  - Arabic mentality
  - Extended family
  - Servant
  - Man authority
  - Man in Arabic countries
  - Relocation
  - Social support
- Settlement
- Arabic beliefs and practices
  - baby sex
  - Birth spacing with Arab
  - Blood
  - Breast feeding
  - Breastfeeding issue with Arab
  - Celebrating delivery in Arabic count
  - Beliefs during labour
  - Beliefs during postpartum

**All Trees**

Title	No.	Passages	Created	Modified
Adaptation	1	12	30/10/20...	01/08/20...
living as nuclear family	2	0	01/08/20...	01/08/20...
Acculturation	3	5	02/11/20...	01/08/20...
Arabic life	4	0	01/08/20...	01/08/20...
Settlement	5	6	30/10/20...	01/08/20...
Arabic beliefs and pr...	6	0	01/08/20...	01/08/20...
Annoying matters	7	0	01/08/20...	01/08/20...
Pregnancy care	8	20	30/10/20...	01/08/20...
Postnatal care	9	0	01/08/20...	01/08/20...
Labour care	10	21	31/10/20...	01/08/20...
Woman's feeling	11	0	01/08/20...	01/08/20...
Positive aspects	12	0	01/08/20...	01/08/20...
Communication	13	0	01/08/20...	01/08/20...
Summary of the exp...	14	8	02/11/20...	01/08/20...
Differences of care	15	0	01/08/20...	01/08/20...

Trees

Start My Computer Appendices NVivo - Nvivo analysi... Node Explorer - Nv... Document1 - Microso...